

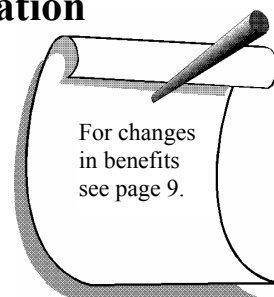
Blue Cross[®] and Blue Shield[®] Service Benefit Plan

<http://www.fepblue.org>



2012

A fee-for-service plan (standard and basic option) with a preferred provider organization



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

- 104 Standard Option - Self Only
- 105 Standard Option - Self and Family
- 111 Basic Option - Self Only
- 112 Basic Option - Self and Family



**ACCREDITED
CASE MANAGEMENT**

Case management accreditation for this Plan is provided either through URAC or through Health Plan accreditation from NCQA.



**ACCREDITED
HEALTH WEB SITE**

This Plan has Health Web Site accreditation from URAC.

See the 2012 FEHB Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**

Healthcare and Insurance
<http://www.opm.gov/insure>

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. The Blue Cross and Blue Shield Association is the Carrier of the Plan. The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan

1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on pages 9-10. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.
 - If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

**OR WRITE TO:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Do not assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
 - “Exactly what will you be doing?”
 - “About how long will it take?”
 - “What will happen after surgery?”
 - “How can I expect to feel during recovery?”
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct never events, if you use Service Benefit Plan Preferred or Member hospitals. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

Section 1. Facts about this fee-for-service Plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

This Plan is a “non-grandfathered health plan” under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this Plan must provide preventive services and screenings to you without any cost-sharing when the services are performed by a Preferred provider; and emergency services performed by Preferred and Non-preferred providers in an emergency department of a hospital are subject to the same member coinsurance or copayment.

Questions regarding what protections apply to a non-grandfathered health plan may be directed to us by calling the customer service number on the back of your Service Benefit Plan ID card or by visiting our Web site, www.fepblue.org. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are “Preferred providers.” When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact your Local Plan to request a PPO directory.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as “Preferred.”** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as “Participating” providers. If they are facilities, we refer to them as “Member” facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as “Non-participating providers” generally, although if they are facilities we refer to them as “Non-member facilities.”** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see pages 132-133). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 14 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM’s FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. **Note:** As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our Web site at www.fepblue.org.

Section 2. How we change for 2012

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (*Benefits*). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Alaska has been added to the list of Medically Underserved Areas for 2012; South Carolina has been removed from the list. (See page 12.)
- Sections 3, 7, and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will decrease for Self Only or decrease for Self and Family. (See page 146.)
- Your coinsurance for generic drugs purchased at a Preferred retail pharmacy is now 15% of the Plan allowance if you have primary coverage under Medicare Part B. Previously, you were responsible for 20% coinsurance for generic drugs when Medicare Part B was primary. (See page 93.)
- Your copayment for generic drugs purchased through the Mail Service Prescription Drug Program is now \$15 per prescription. Previously, your copayment was \$10 for generic drugs. If you have primary coverage under Medicare Part B, your copayment for generic drugs is still \$10 per prescription. (See page 94.)
- Your coinsurance for non-preferred brand-name drugs purchased at a Preferred retail pharmacy is now 45% of the Plan allowance. Previously, you paid 30% of the Plan allowance. (See page 93.)
- Your copayment for non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program is now \$95 per prescription for the first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year and \$50 per prescription thereafter. Previously, your copayment was \$70 for the first 30 non-preferred brand-name prescriptions (\$50 per prescription thereafter). (See page 94.)
- We now offer a Specialty Drug Pharmacy Program that features unique cost-shares for specialty drugs purchased through our Preferred specialty drug pharmacy. Your copayment for specialty drugs purchased through the Specialty Drug Pharmacy Program is \$80 per prescription for the first 30 prescriptions filled (and/or refills ordered) per calendar year and \$50 per prescription thereafter. Previously, if you obtained specialty drugs through the Mail Service Prescription Drug Program, your copayment was \$70 for the first 30 specialty drug prescriptions and \$50 per prescription thereafter. Your cost-share for specialty drugs obtained at a Preferred retail pharmacy is still 30% of the Plan allowance. (See page 95.)
- We expanded the list of generic drug replacements included in our Standard Option Generic Incentive Program. (See page 90.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 146.)
- We now offer a Specialty Drug Pharmacy Program that features unique cost-shares for specialty drugs purchased through our Preferred specialty drug pharmacy. Your copayment for specialty drugs purchased through the Specialty Drug Pharmacy Program is \$40 for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply). Previously, if you obtained specialty drugs at a Preferred retail pharmacy, your copayment was \$40 for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply). (See page 95.)
- Your copayment for specialty drugs obtained at a Preferred retail pharmacy is now \$50 for each purchase of up to a 34-day supply (\$150 copayment for 90-day supply). Previously, your copayment for specialty drugs was \$40 for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply). (See page 93.)
- Your copayment for sleep studies is now \$75. Previously, you had no copayment for these services. (See pages 33 and 75.)

Changes to both our Standard and Basic Options

- You are entitled to receive a \$35 health account to be used for qualified medical expenses when you complete a Blue Health Assessment questionnaire. In addition, you are entitled to receive up to an additional \$15 for completing up to three (3) online coaching modules through Blue Health Connection. Previously under Standard Option, you were entitled to receive a \$50 credit toward meeting your calendar year deductible. Previously under Basic Option, you were entitled to receive a \$35 health account. [See Section 5(h).]

- You are entitled to participate in the Diabetes Management Incentive Program if you indicate that you have diabetes through the Blue Health Assessment questionnaire or Care™ for Diabetes coaching module. [See Section 5(h).]
- We now provide benefits in full up to \$1,250 per hearing aid per ear for hearing aids for children, hearing aids for adults, and bone anchored hearing aids for adults and children, when provided by any qualified hearing aid provider. Costs for hearing aid dispensing fees, accessories, supplies, and repair services are included in the benefit limit. Previously, Standard and Basic Option benefits were limited to \$1,000 per hearing aid and costs for hearing aid dispensing fees and other related services were not included in the benefit limit. (See page 46.)
- We now provide benefits in full up to \$1,250 per calendar year for speech-generating devices obtained from any qualified provider. Previously, Standard and Basic Option benefits were limited to \$1,000 per calendar year. (See page 47.)
- We now provide benefits for specific blood and marrow stem cell transplants when performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). Previously, benefits for specific blood and marrow stem cell transplants were only provided when the transplants were performed in an approved clinical trial at a Cancer Research Facility (CRF). (See pages 14, 63, and 64.)
- We now provide benefits for autologous and nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants for autoimmune diseases (e.g., multiple sclerosis, scleroderma, systemic lupus erythematosus, chronic inflammatory demyelinating polyneuropathy) when provided in a clinical trial at a FACT-accredited facility. Previously, benefits were not available for these services for these conditions. (See pages 63 and 64.)
- We no longer provide benefits for lobar lung transplants performed at Blue Distinction Centers for Transplants. Previously, benefits were available for lobar lung transplants performed at these types of facilities.
- We revised our definition of Experimental or investigational services. (See page 129.)
- We revised our definition of Medical necessity. (See page 130.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail or internet pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any “covered professional provider” or “covered facility provider.” How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those “covered professional providers” or “covered facility providers” that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 14 for the exceptions to this requirement. Refer to page 7 for more information about Preferred providers.

The term “primary care provider” includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

Physicians – Doctors of medicine (M.D.); Doctors of osteopathy (D.O.); Doctors of dental surgery (D.D.S.); Doctors of medical dentistry (D.M.D.); Doctors of podiatric medicine (D.P.M.); Doctors of optometry (O.D.); and Doctors of Chiropractic/chiropractors (D.C.). Reimbursable chiropractic services shall only be those covered services listed under the Chiropractic benefit on page 49; *Manipulative treatment* on page 50; covered services provided in medically underserved areas as described on page 12; and the performance of covered physical therapy evaluations and physical therapy treatment modalities identified on page 43.

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state’s applicable licensing or certification requirements and the requirements of the Local Plan. Other covered health care professionals include:

- **Audiologist** – A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Clinical Psychologist** – A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker** – A social worker who (1) has a master’s or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator** – A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Dietician** – A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory** – A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Lactation Consultant** – A person who is licensed as a Registered Nurse in the United States (or appropriate equivalent if providing services overseas) and is licensed or certified as a lactation consultant by a nationally recognized organization.

- **Mental Health or Substance Abuse professional** – A professional who is licensed by the state where the care is provided to provide mental health and/or substance abuse services within the scope of that license.
- **Nurse Midwife** – A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist** – A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic** – A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient “office” services rather than facility charges.
- **Nutritionist** – A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist** – A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant** – A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Other professional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In the states OPM determines are “medically underserved”:

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is Preferred for any covered service performed within the scope of that license.

For 2012, the states are: Alabama, Alaska, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, and Wyoming.

- **Covered facility providers**

Covered facilities include those listed below, when they meet the state’s applicable licensing or certification requirements.

Hospital – An institution, or a distinct portion of an institution, that:

- (1) Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
- (2) Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
- (3) Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

Freestanding Ambulatory Facility – A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

- (1) Provides services in an outpatient setting;
- (2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
- (3) Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
- (4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

Blue Distinction Centers[®]

Certain Preferred facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, and Complex and Rare Cancers. These facilities meet stringent quality criteria established by expert physician panels, surgeons, and other medical professionals. Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise.

Blue Distinction Centers are Preferred facilities, which means that your out-of-pocket costs for covered facility services are limited. Some Blue Distinction Centers may use professional providers who do not participate in our provider network. Non-participating providers have no agreements with us to limit what they can bill you. This is why it's important to always request Preferred providers for your care. For more information, see pages 21-23 in Section 4, *Your costs for covered services*, or call your Local Plan at the number listed on the back of your ID card. For listings of Preferred providers in your area, visit our Provider Directory at www.fepblue.org.

If you are considering covered bariatric surgery, cardiac procedures, knee or hip replacement, spine surgery, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. You can find these facilities listed in the online Provider Directory available at www.fepblue.org, or by calling the customer service number listed on the back of your ID card.

Blue Distinction Centers for Transplants

In addition to Preferred transplant facilities, you have access to the Blue Distinction Centers for TransplantsSM, a centers of excellence program. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. These facilities negotiate a payment for transplant services performed during the transplant period (see page 134 for the definition of “transplant period”).

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the \$250 per admission copayment under Standard Option, or the \$150 per day copayment (\$750 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services. Regular Preferred benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period.

Blue Distinction Centers for Transplants are available for eight types of transplants: heart; heart-lung; single or double lung; liver; pancreas; simultaneous pancreas-kidney; simultaneous liver-kidney; and autologous or allogeneic blood or marrow stem cell (see page 66 for limitations).

Note: Certain stem cell transplants **must** be performed at a Blue Distinction Centers for Transplants facility (see pages 60-61).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

Cancer Research Facility – A facility that is:

- (1) A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
- (2) An NCI-designated Cancer Center; or
- (3) An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

FACT-Accredited Facility

A facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). FACT-accredited cellular therapy programs meet rigorous standards. Information regarding FACT transplant programs can be obtained by contacting the transplant coordinator at the customer service number listed on the back of your ID card or by visiting www.factwebsite.org.

Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

- (1) Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
- (2) Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
- (3) Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
- (4) Services of assistant surgeons;
- (5) Special provider access situations (contact your Local Plan for more information); or
- (6) Care received outside the United States and Puerto Rico.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

• Transitional care

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

• If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

• Inpatient hospital admission

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for *Other services* (called prior approval), are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a pre-service claim for benefits (1) requires precertification or prior approval and (2) will result in a reduction of benefits if you do not obtain precertification or prior approval.

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

• Other services

You must obtain prior approval for these services under both Standard and Basic Option:

- **Outpatient surgical services** – The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
 - Outpatient surgery for morbid obesity. **Note:** See page 54 for complete surgical requirements;
 - Outpatient surgical correction of congenital anomalies; and
 - Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.

- **Outpatient intensity-modulated radiation therapy (IMRT)** – Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer. Contact us at the customer service number listed on the back of your ID card before receiving outpatient IMRT for cancers which require prior approval. We will request the medical evidence we need to make our coverage determination.
- **Hospice care** – Contact us at the customer service number listed on the back of your ID card before obtaining home hospice, continuous home hospice, or inpatient hospice care services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 77 for information about the exception to this requirement.
- **Organ/tissue transplants** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants** – See pages 63 and 64 for the list of conditions covered **only** in clinical trials for blood or marrow stem cell transplants. Contact us at the customer service number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 63 and 64, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility (see pages 13 and 14) where the procedure is to be delivered.

- **Prescription drugs – Certain prescription drugs require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 98 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy, through an internet pharmacy, or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under **Standard Option**, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. CVS Caremark, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **\$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 15 or is one of the transplant procedures listed on page 16) – even if the charge will be \$5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

How to request precertification for an admission or get prior approval for Other services

First, you, your representative, your physician, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

• Non-urgent care claims

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

• Urgent care claims

If you have an **urgent care claim** (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review of the claim and notify you of our decision within 72 hours as long as we receive sufficient information to complete the review. (For concurrent care claims that are also urgent care claims, please see *If your treatment needs to be extended* on page 18.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone us within two business days, a \$500 penalty may apply – see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of *Other services*, you may request a review by following the procedures listed below. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 128 for definition). (If you have already received the service, supply, or treatment, then your claim is a **post-service claim** and you must follow the entire disputed claims process detailed in Section 8.)

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay, or, if applicable, approve your request for prior approval for the service, drug, or supply; or
2. Write to you and maintain our denial; or
3. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of \$20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of \$250 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is \$350 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach \$700. For families of two, each family member must fully satisfy his or her individual deductible before this "family deductible" is considered met.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$270) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only**, coinsurance does not begin until you meet your deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your \$350 calendar year deductible.

If your provider routinely waives your cost

Note: If your provider routinely waives (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges \$100 for a service but routinely waives your 35% Standard Option coinsurance, the actual charge is \$65. We will pay \$42.25 (65% of the actual charge of \$65).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of *Plan allowance* in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. It is possible for a provider's bill to exceed the plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred or Participating and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges \$250, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our \$100 allowance (\$15). Because of the agreement, your Preferred physician will not bill you for the \$150 difference between our allowance and his/her bill.

Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges \$250 for covered services subject to a \$25 copayment. Even though our allowance may be \$100, you still pay just the \$25 copayment. Because of the agreement, your Preferred physician will not bill you for the \$225 difference between your copayment and his/her bill.

Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges \$250, but the Plan allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our \$100 allowance (\$35). Because of the agreement, your Participating physician will not bill you for the \$150 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our Web site, www.fepblue.org, or call us at the customer service number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pages 132-133). For example, you see a Non-participating physician who charges \$250. The Plan allowance is again \$100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the \$100 Plan allowance or \$35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the \$150 difference between our allowance and his/her bill. This means you would pay a total of \$185 (\$35 + \$150) for the Non-participating physician's services, rather than \$15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

The following table illustrates examples of how much you have to pay out-of-pocket for services from a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges \$250 and the Plan allowance is \$100. For Standard Option, the table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	Preferred physician Standard Option	Preferred physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	\$250	\$250	\$250	\$250
Our allowance	We set it at: 100	We set it at: 100	We set it at: 100	We set it at: 100
We pay	85% of our allowance: 85	Our allowance less copay: 75	65% of our allowance: 65	65% of our allowance: 65
You owe: Coinsurance	15% of our allowance: 15	Not applicable	35% of our allowance: 35	35% of our allowance: 35
You owe: Copayment	Not applicable	25	Not applicable	Not applicable
+Difference up to charge?	No: 0	No: 0	No: 0	Yes: 150
TOTAL YOU PAY	\$15	\$25	\$35	\$185

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 14 for the exceptions to this requirement.

Note: Under Standard Option, had you not met any of your deductible in the above examples, only our allowance (\$100), which you would pay in full, would count toward your deductible.

**Important notice about
Non-Participating
providers!**

Preferred hospitals may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay 15% of the Non-participating Provider Allowance plus any difference between that allowance and the amount billed (after the member's \$350 calendar year deductible has been satisfied), for services provided in Preferred facilities by Non-participating anesthesiologists (see page 52). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred Provider Allowance after meeting the \$350 calendar year deductible.

In this example, the Non-participating anesthesiologist charges \$1,200 for his/her services. Our Non-participating Provider Allowance for those services is \$400. For the Non-preferred anesthesiologist's services, you would be responsible for paying 15% of the allowance (\$60), plus the \$800 difference between the allowance and the amount billed, for a total of \$860. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the \$400 allowance (after meeting your deductible), or \$60, resulting in a savings to you of \$800 (\$860 - \$60 = \$800).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our Web site, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using a customary percentage of the billed charge as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care.** Under Standard Option, we pay scheduled amounts for routine dental services and you pay any balance. Under Basic Option, you pay \$25 for any covered evaluation and we pay the balance for covered services. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). Under Standard Option, you must meet your deductible before we begin providing benefits for certain hospital-billed services. Under Basic Option, you must use Preferred facilities in order to receive benefits. See page 14 for the exceptions to this requirement.

**Your catastrophic
protection out-of-pocket
maximum for
deductibles, coinsurance,
and copayments**

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for coinsurance and copayments (other than those listed below) exceeds \$7,000 under Standard Option, or \$5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$5,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach \$7,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 22-23;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your calendar year deductible;
- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The \$500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-preferred brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 14 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 23 and on this page until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 23 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount – the “equivalent Medicare amount” – set by Medicare’s rules for what Medicare would pay, not on the actual charge.
- You are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on:

- an amount set by Medicare and called the “Medicare approved amount,” or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	Then you are responsible for:	
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments.
	Basic Option:	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount.
	Basic Option:	all charges.
Does not participate with Medicare, and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount.
		Note: In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.
Does not participate with Medicare and is not in our Preferred network	Standard Option:	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	all charges.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

**When you have the
Original Medicare Plan
(Part A, Part B, or both)**

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment (see note below for Basic Option).

Note: Under Basic Option, you must see **Preferred** providers in order to receive benefits. See page 14 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Standard and Basic Option Benefits

See pages 9-10 for how our benefits changed this year. Page 144 and page 145 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

Standard Option

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a \$20 copayment for office visits to primary care providers (\$30 for specialists). Standard Option also features a Preferred retail pharmacy program, a Preferred mail service drug program, and a Preferred specialty drug pharmacy program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments (\$25 for primary care providers and \$35 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program and a Preferred specialty drug pharmacy program.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
 - We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does <i>not</i> apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	Standard Option	Basic Option
<p>Professional services of physicians and other health care professionals:</p> <ul style="list-style-type: none">• Outpatient consultations• Outpatient second surgical opinions• Office visits• Home visits• Initial examination of a newborn needing definitive treatment when covered under a family enrollment• Pharmacotherapy (medication management) [see Section 5(f) for prescription drug coverage] <p>Note: Please refer to pages 32-33 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a physician, and to pages 73-75 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for the office visit charge (No deductible)</p> <p>Preferred specialist: \$30 copayment for the office visit charge (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient professional services:</p> <ul style="list-style-type: none">• During a hospital stay• Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission• Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits <p>Note: A consulting physician employed by the hospital is not the attending physician.</p> <ul style="list-style-type: none">• Consultations when requested by the attending physician• Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care• Physical therapy by a physician other than the attending physician• Initial examination of a newborn needing definitive treatment when covered under a family enrollment• Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs you receive while in the hospital]• Second surgical opinion• Nutritional counseling when billed by a covered provider	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Diagnostic and treatment services (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine services except for those Preventive care services described on pages 34-37 • Telephone consultations and online medical evaluation and management services • Private duty nursing • Standby physicians • Routine radiological and staff consultations required by hospital rules and regulations • Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)] <p>Note: If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.</p>	All charges	All charges
<p>Lab, X-ray, and other diagnostic tests</p> <p>Diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • Blood tests • EKGs • Laboratory tests • Neurological testing • Pathology services • Urinalysis <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: Nothing</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

Lab, X-ray, and other diagnostic tests – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Lab, X-ray, and other diagnostic tests (continued)	You Pay	
	Standard Option	Basic Option
<p>Diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • EEGs • Ultrasounds • X-rays (including set-up of portable X-ray equipment) <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: \$25 copayment</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.</p>
<p>Diagnostic tests provided, or ordered and billed by a physician, limited to:</p> <ul style="list-style-type: none"> • Bone density tests – diagnostic • CT scans/MRIs/PET scans • Diagnostic angiography • Genetic testing – diagnostic <p>Note: Genetic screening is not covered.</p> <ul style="list-style-type: none"> • Nuclear medicine • Sleep studies <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: \$75 copayment</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Preventive care, adult	You Pay	
	Standard Option	Basic Option
<p>We provide benefits for a comprehensive range of preventive care services for adults age 22 and over, including the preventive services recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). Covered services include:</p> <ul style="list-style-type: none"> • Routine physical examination • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile • Screening for alcohol/substance abuse <p>Note: See page 51 for our coverage of smoking and tobacco cessation treatment.</p> <ul style="list-style-type: none"> • Individual counseling on prevention and reducing health risks <p>Note: Preventive care benefits are not available for group counseling.</p> <ul style="list-style-type: none"> • Genetic counseling and evaluation for women whose family history is associated with an increased risk for harmful mutations in BRCA1 or BRCA2 genes <p>Note: BRCA testing is covered only for members with a cancer diagnosis. See page 33 for the benefit levels that apply to diagnostic genetic testing.</p> <ul style="list-style-type: none"> • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection • Administration and interpretation of a Health Risk Assessment (HRA) questionnaire (see <i>Definitions</i>) <p>Note: As a member of the Service Benefit Plan, you have access to the Blue Cross and Blue Shield HRA, called the “Blue Health Assessment” questionnaire. Completing the questionnaire entitles you to receive special benefit incentives. See Section 5(h) for complete information.</p> <p>Note: Preventive care benefits for each of the services listed above are limited to one per calendar year.</p> <p>Note: If the primary purpose of your office visit to a Preferred provider is other than preventive care, you pay the copayment amount shown on page 31. The copayment applies even if you receive a covered preventive service during the visit.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for routine physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>

Preventive care, adult – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Preventive care, adult (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Colorectal cancer tests, including: <ul style="list-style-type: none"> Fecal occult blood test Screening colonoscopy (see page 53 for our payment levels for colonoscopies performed by a physician to diagnose or treat a specific condition) Sigmoidoscopy Double contrast barium enema Prostate cancer tests – Prostate Specific Antigen (PSA) test Cervical cancer tests (including Pap tests) Breast cancer tests (mammograms) Ultrasound for aortic abdominal aneurysm Osteoporosis screening – annual screening for women age 60 and over <p>Note: Preventive care benefits for each of the services listed above are limited to one per calendar year.</p> <ul style="list-style-type: none"> Nutritional counseling when billed by a covered provider such as a physician, nurse, nurse practitioner, licensed certified nurse midwife, dietician or nutritionist, who bills independently for nutritional counseling services <p>Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services.</p> <p>Note: If the primary purpose of your office visit to a Preferred provider is other than preventive care, you pay the copayment amount shown on page 31. The copayment applies even if you receive a covered preventive service during the visit.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for routine physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>
<p>Routine immunizations [as licensed by the U.S. Food and Drug Administration (FDA)], limited to:</p> <ul style="list-style-type: none"> Hepatitis (Types A and B) for patients with increased risk or family history Herpes Zoster (shingles)* Human Papillomavirus (HPV)* Influenza (flu)* Measles, Mumps, Rubella Meningococcal* Pneumococcal* Tetanus, Diphtheria, Pertussis booster (one every 10 yrs) Varicella <p>*Many Preferred retail pharmacies participate in our vaccine network. See page 92 for our coverage of these vaccines when provided by pharmacies in the vaccine network.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: We waive your deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>

Preventive care, adult – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Preventive care, adult (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed on page 35 to certain age ranges, frequencies, and/or other patient-specific indications, including gender.</p> <p>Note: If the primary purpose of your office visit to a Preferred provider is other than preventive care, you pay the copayment amount shown on page 31. The copayment applies even if you receive a covered preventive service during the visit.</p> <p>Note: See page 92 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: The benefits listed on pages 34-35 do not apply to children up to age 22. (See benefits under <i>Preventive care, children</i>, this Section.)</p> <p>Note: A complete list of the preventive care services recommended under the Affordable Care Act is available online at: www.healthcare.gov/law/about/provisions/services/lists.html. Services recommended under the Act and guidelines for health plan coverage are subject to Federal regulations.</p>	See pages 34-35	See pages 34-35
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Genetic screening related to family history of cancer or other disease (see page 33 for our coverage of medically necessary diagnostic genetic testing) • Group counseling on prevention and reducing health risks • Self-administered health risk assessments (other than the Blue Health Assessment) • Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans 	All charges	All charges

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Preventive care, children	You Pay	
	Standard Option	Basic Option
<p>We provide benefits for a comprehensive range of preventive care services for children up to age 22, including the preventive services recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”), and services recommended by the American Academy of Pediatrics (AAP). Covered services include:</p> <ul style="list-style-type: none"> • Healthy newborn visits and screenings (inpatient or outpatient) • Routine physical examinations • Laboratory tests • Hearing and vision screenings • Routine immunizations as licensed by the U.S. Food and Drug Administration (FDA) limited to: <ul style="list-style-type: none"> – Diphtheria, Tetanus, Pertussis – Hemophilus Influenza type b (Hib) – Hepatitis (Types A and B) – Human Papillomavirus (HPV) – Inactivated Poliovirus – Measles, Mumps, Rubella – Meningococcal – Pneumococcal – Rotavirus – Influenza (flu) – Varicella <p>Note: U.S. FDA licensure may restrict the use of certain immunizations and vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender.</p> <ul style="list-style-type: none"> • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection <p>Note: Benefits for sexually transmitted infection (STI) screening tests are limited to one test per STI per year.</p> <ul style="list-style-type: none"> • Nutritional counseling services (see page 35) <p>Note: See page 92 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: If the primary purpose of your child’s office visit to a Preferred provider is other than preventive care, you pay the copayment amount shown on page 31. The copayment applies even if your child receives a covered preventive service during the visit.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: We waive the deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: For services billed by Participating/Non-participating providers related to Influenza (flu) vaccines, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Maternity care	You Pay	
	Standard Option	Basic Option
<p>Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as:</p> <ul style="list-style-type: none"> • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) <p>Note: Maternity care benefits are not provided for oral tocolytic agents. See Section 5(f) for prescription drug coverage (including oral tocolytic agents).</p> <p>Note: Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 49.</p> <ul style="list-style-type: none"> • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant • Breastfeeding education and individual coaching on breastfeeding by a physician, physician assistant, nurse midwife, nurse practitioner/clinical specialist, or registered nurse certified lactation consultant • Mental health treatment for postpartum depression and depression during pregnancy <p>Note: We provide benefits to cover up to 4 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage of mental health visits to Non-preferred providers and benefits for additional mental health services.</p> <p>Note: See page 35 for our coverage of nutritional counseling.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be \$5,000 or more. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.</p>	<p>Preferred: Nothing</p> <p>Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to \$150 per admission. For outpatient facility services related to maternity, see page 72.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.</p>

Maternity care – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Maternity care <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: See page 53 for our payment levels for circumcision.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest</i> <i>Genetic testing/screening of the baby’s father (see page 33 for our coverage of medically necessary diagnostic genetic testing)</i> <i>Maternity care for women not enrolled in this Plan</i> 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Family planning	You Pay	
	Standard Option	Basic Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Depo-Provera • Diaphragms and contraceptive rings • Intrauterine devices (IUDs) • Implantable contraceptives • Oral and transdermal contraceptives • Voluntary sterilization [see <i>Surgical procedures</i> in Section 5(b)] <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay \$150 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Contraceptive devices not described above 	<i>All charges</i>	<i>All charges</i>
Infertility services		
<p>Diagnosis and treatment of infertility, except as shown in <i>Not covered</i></p> <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

Infertility services – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Infertility services (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Assisted reproductive technology (ART) procedures, including but not limited to: <ul style="list-style-type: none"> Artificial insemination (AI) In vitro fertilization (IVF) Embryo transfer and Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT) Intravaginal insemination (IVI) Intracervical insemination (ICI) Intracytoplasmic sperm injection (ICSI) Intrauterine insemination (IUI) Services and supplies related to ART procedures, such as sperm banking Infertility drugs used in conjunction with ART procedures 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> Testing and treatment, including materials (such as allergy serum) Allergy injections 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit; nothing for injections</p> <p>Preferred specialist: \$35 copayment per visit; nothing for injections</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Treatment therapies	You Pay	
	Standard Option	Basic Option
<p>Outpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy Note: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under <i>Organ/tissue transplants</i> in Section 5(b). See also, <i>Other services</i> under <i>You need prior Plan approval for certain services</i> in Section 3 (pages 15-16). Intensity-modulated radiation therapy (IMRT) Note: You must get prior approval for outpatient IMRT related to cancers other than head, neck, breast, or prostate cancer. Please refer to page 16 for more information. Renal dialysis – Hemodialysis and peritoneal dialysis Intravenous (IV)/infusion therapy – Home IV or infusion therapy Note: Home nursing visits associated with Home IV/infusion therapy are covered as shown under <i>Home health services</i> on page 49. Outpatient cardiac rehabilitation Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See page 50 for our coverage of osteopathic and chiropractic manipulative treatment. 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy Note: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under <i>Organ/tissue transplants</i> in Section 5(b). See also, <i>Other services</i> under <i>You need prior Plan approval for certain services</i> in Section 3 (pages 15-16). Renal dialysis – Hemodialysis and peritoneal dialysis Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies] 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Physical therapy, occupational therapy, speech therapy, and cognitive therapy	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician Cognitive rehabilitation therapy when performed by a licensed therapist or physician <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit (No deductible)</p> <p>Preferred specialist: \$30 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay Maintenance or palliative rehabilitative therapy Exercise programs Hippotherapy (exercise on horseback) Services provided by massage therapists 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Hearing services (testing, treatment, and supplies)	You Pay	
	Standard Option	Basic Option
<p>Hearing tests related to illness or injury</p> <p>Note: For our coverage of hearing aids and related services, see page 46.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine hearing tests (except as indicated on page 37) • Hearing aids (except as described on page 46) • Testing and examinations for the prescribing or fitting of hearing aids (except as needed for covered hearing aids described on page 46) 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<p>Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed:</p> <ul style="list-style-type: none"> • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition; • For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 <p>Note: Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>

Vision services (testing, treatment, and supplies) – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Vision services (testing, treatment, and supplies) (continued)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Eye examinations related to a specific medical condition Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 <p>Note: See page 44 for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus.</p> <p>Note: See Section 5(b), <i>Surgical procedures</i>, for coverage for surgical treatment of amblyopia and strabismus.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment (No deductible)</p> <p>Preferred specialist: \$30 copayment (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 44 Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc. Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above LASIK, INTACS, radial keratotomy, and other refractive services except as described on page 44 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p> <p>Note: See Section 5(b) for our coverage for surgical procedures.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies)</p> <p>Preferred specialist: \$30 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>

Foot care – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Foot care (continued)	You Pay	
	Standard Option	Basic Option
<i>Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated on page 45</i>	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices		
<p>Orthopedic braces and prosthetic appliances such as:</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Surgically implanted penile prostheses to treat erectile dysfunction <p>Note: A prosthetic appliance is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.</p> <p>We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Hearing aids for children up to age 22, limited to \$1,250 per ear per calendar year • Hearing aids for adults age 22 and over, limited to \$1,250 per ear per 36-month period • Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to \$1,250 per ear per calendar year <p>Note: Benefits for hearing aid dispensing fees, accessories, supplies, and repair services are included in the benefit limits described above.</p>	Any amount over \$1,250 per hearing aid per ear (No deductible)	Any amount over \$1,250 per hearing aid per ear
<ul style="list-style-type: none"> • Wigs for hair loss due to chemotherapy for the treatment of cancer <p>Note: Benefits for wigs are paid at 100% of the billed amount, limited to \$350 for one wig per lifetime.</p>	Any amount over \$350 for one wig per lifetime (No deductible)	Any amount over \$350 for one wig per lifetime

Orthopedic and prosthetic devices – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Orthopedic and prosthetic devices (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Shoes and over-the-counter orthotics • Arch supports • Heel pads and heel cups • Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to chemotherapy for the treatment of cancer, as stated on page 46 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)		
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Continuous passive motion (CPM) devices • Dynamic orthotic cranioplasty (DOC) devices • Other items that we determine to be DME, such as compression stockings <p>Note: We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>
<ul style="list-style-type: none"> • Speech-generating devices, limited to \$1,250 per calendar year 	Any amount over \$1,250 per year (No deductible)	Any amount over \$1,250 per year

Durable medical equipment – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Durable medical equipment (DME) (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Exercise and bathroom equipment • Lifts, such as seat, chair, or van lifts • Car seats • Air conditioners, humidifiers, dehumidifiers, and purifiers • Breast pumps • Communications equipment, devices, and aids (including computer equipment) such as “story boards” or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed on page 47) • Equipment for cosmetic purposes • Topical Hyperbaric Oxygen Therapy (THBO) 	<i>All charges</i>	<i>All charges</i>
Medical supplies		
<ul style="list-style-type: none"> • Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) <p>Note: See Section 10, <i>Definitions</i>, for more information about medical foods.</p> <ul style="list-style-type: none"> • Ostomy and catheter supplies • Oxygen <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility.</p> <ul style="list-style-type: none"> • Blood and blood plasma, except when donated or replaced, and blood plasma expanders <p>Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<i>Not covered: Infant formulas used as a substitute for breastfeeding</i>	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Home health services	You Pay	
	Standard Option	Basic Option
<p>Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient’s family • Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter • Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home, except as included in the benefits described on page 76 • Private duty nursing 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Chiropractic		
<ul style="list-style-type: none"> • One office visit per calendar year • One set of X-rays per calendar year <p>Note: See page 50 for our coverage of osteopathic and chiropractic manipulative treatment.</p> <p>Note: Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 12 for additional information.</p>	<p>Preferred: \$20 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Office visits and X-rays that you pay for while meeting your calendar year deductible count toward the appropriate benefit limit.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Manipulative treatment	You Pay	
	Standard Option	Basic Option
<p>Manipulative treatment performed by a Doctor of Osteopathy (D.O.), Doctor of Medicine (M.D.), or Doctor of Chiropractic (D.C.) when the provider is practicing within the scope of his/her license, limited to:</p> <ul style="list-style-type: none"> • Osteopathic manipulative treatment to any body region • Chiropractic spinal and/or extraspinal manipulative treatment <p>Note: Benefits for manipulative treatment, including treatment performed in a medically underserved area, are limited to the services and combined treatment visits stated here.</p> <p>Note: Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 12 for additional information.</p>	<p>Preferred: \$20 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 12 visits per person, per calendar year.</p> <p>Note: Manipulation visits that you pay for while meeting your calendar year deductible count toward the treatment limit cited above.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 visits per person, per calendar year.</p> <p>Participating/Non-participating: You pay all charges</p>
Alternative treatments		
<p>Acupuncture</p> <p>Note: See page 67 for our coverage of acupuncture when provided as anesthesia for covered surgery.</p> <p>Note: See page 38 for our coverage of acupuncture when provided as anesthesia for covered maternity care.</p> <p>Note: We may also cover services of certain alternative treatment providers in medically underserved areas. See page 12 for additional information.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Acupuncture must be performed and billed by a physician or licensed acupuncturist.</p> <p>Note: Benefits for acupuncture are limited to 24 visits per calendar year.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p>	<p>Preferred primary care physician: \$25 copayment per visit</p> <p>Preferred physician specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Note: Acupuncture must be performed and billed by a physician.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services you receive from noncovered providers such as:</i> <ul style="list-style-type: none"> – <i>Naturopaths</i> – <i>Hypnotherapists</i> • <i>Biofeedback</i> • <i>Self-care or self-help training</i> 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Educational classes and programs	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Smoking and tobacco cessation treatment Individual counseling for smoking and tobacco use cessation <p>Note: Benefits are not available for group counseling.</p> <ul style="list-style-type: none"> Smoking and tobacco cessation classes <p>Note: See Section 5(f) for our coverage of smoking and tobacco cessation drugs.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> Diabetic education when billed by a covered provider <p>Note: We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program.</p> <p>Note: See pages 35 and 37 for our coverage of nutritional counseling services that are not part of a diabetic education program.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Marital, family, educational, or other counseling or training services when performed as part of an educational class or program</i> <i>Premenstrual syndrome (PMS), lactation (except as described on page 38), headache, eating disorder (except as described on pages 35 and 37), and other educational clinics</i> <i>Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay</i> <i>Services performed or billed by a school or halfway house or a member of its staff</i> <i>Applied behavior analysis (ABA)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 15 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” to show when the calendar year deductible does not apply.
 - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
 - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **\$5,000 or more**. See page 17 for more information.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
 - We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.

Benefit Description	You Pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.</p> <p>We say “(No deductible)” when the Standard Option deductible does <i>not</i> apply.</p> <p>There is no calendar year deductible under Basic Option.</p>		
Surgical procedures	Standard Option	Basic Option
<p>A comprehensive range of services provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none">• Operative procedures• Treatment of fractures and dislocations, including casting• Normal pre- and post-operative care by the surgeon• Correction of amblyopia and strabismus• Colonoscopy (with or without biopsy) to diagnose or treat a specific condition <p>Note: See page 35 for our coverage of screening colonoscopies billed for by a physician or other covered health care professional.</p> <ul style="list-style-type: none">• Other endoscopy procedures• Biopsy procedures• Removal of tumors and cysts• Correction of congenital anomalies (see <i>Reconstructive surgery</i> on page 56)• Treatment of burns• Circumcision of newborn• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device.• Voluntary sterilization (e.g., tubal ligation, vasectomy)• Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures• Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with one or more co-morbidities; eligible members must be age 18 or over <p>Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on page 54.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 17 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>

Surgical procedures – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Surgical procedures <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Note: Prior approval is required for outpatient surgery for morbid obesity. For more information about prior approval, please refer to page 15.</p> <ul style="list-style-type: none"> Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. The member must meet all requirements. <ul style="list-style-type: none"> Diagnosis of morbid obesity (as defined on page 53) for a period of 2 years prior to surgery Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery. (Note: Benefits are not available for commercial weight loss programs; see page 35 for our coverage of nutritional counseling services.) Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise Evidence that attempts at weight loss in the 1 year period prior to surgery have been ineffective Psychological clearance of the member’s ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner (see page 86 for our payment levels for mental health services) Member has not smoked in the 6 months prior to surgery Member has not been treated for substance abuse for 1 year prior to surgery and there is no evidence of substance abuse during the 1-year period prior to surgery Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements: <ul style="list-style-type: none"> All criteria listed above for the initial procedure must be met again Previous surgery for morbid obesity was at least 2 years prior to repeat procedure Weight loss from the initial procedure was less than 50% of the member’s excess body weight at the time of the initial procedure Member complied with previously prescribed post-operative nutrition and exercise program Claims for the surgical treatment of morbid obesity must include documentation from the member’s provider(s) that all pre-surgical requirements have been met. 		

Surgical procedures – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Surgical procedures <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure.</p> <p>Note: We do not pay extra for “incidental” procedures (those that do not add time or complexity to patient care).</p> <p>Note: When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby physician</i> • <i>Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]</i> • <i>Cosmetic surgery</i> • <i>LASIK, INTACS, radial keratotomy, and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Reconstructive surgery	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. <p>Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.</p> <p>Note: You must get prior approval for outpatient surgical correction of congenital anomalies. Please refer to page 15 for more information.</p> <ul style="list-style-type: none"> Treatment to restore the mouth to a pre-cancer state All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> Surgery to produce a symmetrical appearance of the patient’s breasts Treatment of any physical complications, such as lymphedemas <p>Note: Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility.</p> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> Surgery for placement of penile prostheses to treat erectile dysfunction 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 17 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)</i> <i>Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown above</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Oral and maxillofacial surgery	You Pay	
	Standard Option	Basic Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary Surgery needed to correct accidental injuries (see <i>Definitions</i>) to jaws, cheeks, lips, tongue, roof and floor of mouth <p>Note: You must get prior approval for outpatient surgery needed to correct accidental injuries as described above. Please refer to page 15 for more information.</p> <ul style="list-style-type: none"> Excision of exostoses of jaws and hard palate Incision and drainage of abscesses and cellulitis Incision and surgical treatment of accessory sinuses, salivary glands, or ducts Reduction of dislocations and excision of temporomandibular joints Removal of impacted teeth <p>Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.</p>	<p>Preferred: 15% of the Plan allowance Participating: 35% of the Plan allowance Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 17 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g) Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g) Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g) Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g) 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Organ/tissue transplants	You Pay	
	Standard Option	Basic Option
<p>Solid organ transplants (see below) are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 (see page 16) for prior approval procedures.</p> <p>Note: You must obtain prior approval (see page 16) for those transplants listed under <i>Prior Approval Requirements</i> on page 62.</p> <p>Note: Refer to page 15 for information about precertification of inpatient care.</p>		
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart-lung • Simultaneous pancreas-kidney • Simultaneous liver-kidney • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung • For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 17 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)	You Pay	
	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Physicians consider many features to determine how diseases will respond to different types of treatments. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Myeloablative allogeneic blood or marrow stem cell transplants for: <ul style="list-style-type: none"> – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Chronic myelogenous leukemia – Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) – High-risk neuroblastoma – Hodgkin’s lymphoma – Infantile malignant osteopetrosis – Inherited metabolic disorders (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) – Marrow failure [i.e., severe or very severe aplastic anemia, Fanconi’s Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] – MDS/MPN [e.g., Chronic myelomonocytic leukemia (CMML)] – Myelodysplasia/Myelodysplastic syndromes (MDS) – Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) – Non-Hodgkin’s lymphoma (e.g., Waldenstrom’s macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Primary Immunodeficiencies (e.g., Severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann’s syndrome, Leukocyte adhesion deficiencies) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses <i>(continued from page 59)</i>. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Myeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan. <ul style="list-style-type: none"> – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan. <ul style="list-style-type: none"> – Acute non-lymphocytic (myelogenous) leukemia/acute lymphocytic leukemia – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with poor response to therapy; short time to progression; transformed disease; or high risk disease – Chronic myelogenous leukemia – Hemoglobinopathy (Sickle-cell anemia, Thalassemia major) – Hodgkin’s lymphoma – Inherited Metabolic disorders (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) – Marrow failure (severe or very severe aplastic anemia, Fanconi’s Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia) – MDS/MPN [e.g., chronic myelomonocytic leukemia (CMML)] – Myelodysplasia/myelodysplastic syndromes (MDS) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)	You Pay	
	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (continued from page 60). For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan (continued from page 60). <ul style="list-style-type: none"> Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) Non-Hodgkin’s lymphoma (e.g., Waldenstrom’s macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] Primary Immunodeficiencies (Severe combined immunodeficiency, Wiskott-Aldrich syndrome, Hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann’s syndrome, Leukocyte adhesion deficiencies) Autologous blood or marrow stem cell transplants for: <ul style="list-style-type: none"> Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia Ependyoblastoma Ewing’s sarcoma Germ cell tumors High-risk neuroblastoma Hodgkin’s lymphoma Medulloblastoma Non-Hodgkin’s lymphoma (e.g., Waldenstrom’s macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) Pineoblastoma Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Organ/tissue transplants <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Prior approval requirements:</p> <p>You must obtain prior approval (see page 16) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:</p> <ul style="list-style-type: none"> • Blood or marrow stem cell transplant procedures <p>Note: See pages 63 and 64 for services related to blood or marrow stem cell transplants covered under clinical trials.</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant • Heart • Heart-lung • Intestinal transplants (small intestine with or without other organs) • Liver • Lung (single, double, or lobar) • Pancreas • Simultaneous liver-kidney • Simultaneous pancreas-kidney 		

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>(1) For the following blood or marrow stem cell transplant procedures, we provide benefits only when conducted at a Cancer Research Facility, a Blue Distinction Centers for Transplants facility, or a Foundation for the Accreditation of Cellular Therapy (FACT) accredited facility (see pages 13 and 14) and only when performed as part of a clinical trial that meets the requirements listed on page 64:</p> <ul style="list-style-type: none"> • Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants for: <ul style="list-style-type: none"> – Breast cancer – Colon cancer – Epidermolysis bullosa – Ovarian cancer – Prostate cancer – Renal cell carcinoma – Sarcoma • Autologous blood or marrow stem cell transplants for: <ul style="list-style-type: none"> – Breast cancer – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Chronic myelogenous leukemia – Epithelial ovarian cancer <p>Note: If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the requirements shown on page 64 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.</p> <p>(2) For the following procedures, we provide benefits only when conducted at a FACT-accredited facility (see page 14) and only when performed as part of a clinical trial that meets the requirements listed on page 64:</p> <ul style="list-style-type: none"> • Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants or autologous blood or marrow stem cell transplants for: <ul style="list-style-type: none"> – Autoimmune disease (e.g., Multiple sclerosis, Scleroderma, Systemic lupus erythematosus, Chronic inflammatory demyelinating polyneuropathy) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>(3) Requirements for blood or marrow stem cell transplants covered under clinical trials:</p> <p>For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials:</p> <ul style="list-style-type: none"> • You must contact us at the customer service number listed on the back of your ID card to obtain prior approval (see page 16); • The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. <p>Note: Clinical trials are research studies in which physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. A clinical trial has possible benefits as well as risks. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial. Information regarding clinical trials is available at www.cancer.gov.</p> <p>Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Cancer Research Facility or FACT-accredited facility to treat your condition at the time you seek to be included in a clinical trial. If your physician has recommended you participate in a clinical trial, we encourage you to contact the Case Management Department at your Local Plan for assistance.</p> <p>Note: See page 127 for our coverage of other costs associated with clinical trials.</p>		

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Related transplant services:</p> <ul style="list-style-type: none"> Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 59-61, or pages 63-64 <p>Note: Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells.</p> <ul style="list-style-type: none"> Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 59-61, or pages 63-64 Related medical and hospital expenses of the donor, when we cover the recipient Related services or supplies provided to the recipient Donor screening tests for up to three non-full sibling (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for transplant <p>Note: See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)

Organ/Tissue Transplants at Blue Distinction Centers for Transplants

We participate in the Blue Distinction Centers for TransplantsSM program, a centers of excellence program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility.

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous liver-kidney
- Simultaneous pancreas-kidney
- Single or double (bilateral) lung
- Blood or marrow stem cell transplants listed on pages 60-61 and page 63
- Related transplant services listed on page 65

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 58 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 13).

Note: See pages 59-64 for requirements related to blood or marrow stem cell transplant coverage.

Note: See page 13 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Transplants for any diagnosis not listed as covered • Donor screening tests and donor search expenses, except as defined on page 65 • Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Anesthesia	You Pay	
	Standard Option	Basic Option
<p>Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by:</p> <ul style="list-style-type: none"> • A certified registered nurse anesthetist (CRNA), or • A physician other than the physician (or the assistant) performing the covered medical or surgical procedure <p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness.</p> <p>Note: See Section 5(c) for our payment levels for anesthesia services billed by a facility.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- **Note: Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 72. See page 131 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 15 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible of \$350 per person (\$700 per family) applies to only a few benefits in this Section. Unlike in Sections 5(a) and 5(b), we added “(calendar year deductible applies)” when it applies.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.		
Inpatient hospital	Standard Option	Basic Option
<p>Room and board, such as:</p> <ul style="list-style-type: none">• Semiprivate or intensive care accommodations• General nursing care• Meals and special diets <p>Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 132 for more information.</p>	<p>Preferred: \$250 per admission copayment for unlimited days</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment</p> <p>Note: If you are admitted to a Member or Non-member facility due to a medical emergency or accidental injury, you pay a \$350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Inpatient hospital (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic studies, radiology services, laboratory tests, and pathology services • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation <p>Note: Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 72. See page 131 for more information about these types of services.</p> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). <p>Note: See pages 38-39 for other covered maternity services.</p> <p>Note: See page 48 for coverage of blood and blood products.</p>	<p>Preferred: \$250 per admission copayment for unlimited days</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility.</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Note: For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to \$150 per admission.</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Inpatient hospital (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <p><i>Hospital room and board expenses when, in our judgment, a hospital admission or portion of an admission is:</i></p> <ul style="list-style-type: none"> • <i>Custodial or long term care</i> • <i>Convalescent care or a rest cure</i> • <i>Domiciliary care provided because care in the home is not available or is unsuitable</i> • <i>Not medically necessary, such as when services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician’s office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:</i> <ul style="list-style-type: none"> – <i>Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician’s office)</i> – <i>Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician’s office)</i> <p>Note: <i>If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers (see pages 12-14).</i></p> <ul style="list-style-type: none"> • <i>Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers</i> • <i>Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services</i> • <i>Private duty nursing</i> 	<i>All charges</i>	<i>All charges</i>

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center	You Pay	
	Standard Option	Basic Option
<p>Outpatient surgical and medical services performed and billed by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Observation services <p>Note: Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on this page. See page 131 for more information about these types of services.</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy • Colonoscopy (with or without biopsy) to diagnose or treat a specific condition <p>Note: See page 35 for our coverage of screening colonoscopies.</p> <ul style="list-style-type: none"> • Intravenous (IV)/infusion therapy • Cardiac rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy • Routine physical examinations and screening procedures • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency medical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Facility supplies for hemophilia home care • Other medical supplies, including oxygen <p>Note: See pages 81-84 for our payment levels for care related to a medical emergency or accidental injury.</p>	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: See pages 34-37 for our payment levels for covered preventive care services for adults and children.</p> <p>Note: See page 43 for our coverage of physical, occupational, and speech therapy.</p>	<p>Preferred: \$75 copayment per day per facility (except as noted below)</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the \$75 copayment amount and pay for covered services in full when you use a Preferred facility.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p> <p>Member/Non-member: You pay all charges (except for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm as noted below)</p> <p>Note: For covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by a Preferred, Member, or Non-member facility, you pay nothing. Benefits are not available for screening colonoscopies performed at Member or Non-member facilities.</p> <p>Note: You pay nothing for routine adult physical examinations and associated tests when performed at Preferred facilities. Benefits are not available for routine adult physical examinations performed at Member or Non-member facilities.</p> <p>Note: See page 35 for our payment levels for routine adult immunizations and page 37 for preventive care services for children.</p>

Outpatient hospital or ambulatory surgical center – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Note: See page 75 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility.</p> <p>Note: We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries.</p> <p>We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), <i>Dental benefits</i>, for additional benefit information.</p> <p>Note: See pages 38-39 for other covered maternity services.</p>		
<ul style="list-style-type: none"> Laboratory tests and pathology services EKGs 	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: See pages 34-37 for our payment levels for covered preventive care services for adults and children.</p>	<p>Preferred: Nothing</p> <p>Note: You may be responsible for paying a \$75 copayment per day per facility if other medical services are billed in addition to the services listed here.</p> <p>Member: Nothing</p> <p>Non-member: You pay any difference between our allowance and the billed amount</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p>

Outpatient hospital or ambulatory surgical center – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> • EEGs • Ultrasounds • X-rays (including set-up of portable X-ray equipment) 	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: See pages 34-37 for our payment levels for covered preventive care services for adults and children.</p>	<p>Preferred: \$25 copayment per day per facility</p> <p>Note: You may be responsible for paying a \$75 copayment per day per facility if other medical services are billed in addition to the procedures listed here.</p> <p>Member: \$25 copayment per day per facility</p> <p>Non-member: \$25 copayment per day per facility plus the difference between our allowance and the billed amount</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p>

Outpatient hospital or ambulatory surgical center – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Diagnostic tests limited to:</p> <ul style="list-style-type: none"> Bone density tests – diagnostic CT scans/MRIs/PET scans Diagnostic angiography Genetic testing – diagnostic <p>Note: Genetic screening is not covered.</p> <ul style="list-style-type: none"> Nuclear medicine Sleep studies 	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: See pages 34-37 for our payment levels for covered preventive care services for adults and children.</p>	<p>Preferred: \$75 copayment per day per facility</p> <p>Member: \$75 copayment per day per facility</p> <p>Non-member: \$75 copayment per day per facility plus the difference between our allowance and the billed amount</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 128 for more information about “agents.”)</p>
<p>Outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> Prescribed drugs Orthopedic and prosthetic devices Durable medical equipment 	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.</p> <p>Member/Non-member facilities: 35% of the Plan allowance (calendar year deductible applies)</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Note: You may also be responsible for paying a copayment per day per facility for outpatient services. See above and pages 72-74 for specific coverage information.</p> <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the member cost-sharing amounts shown above and pay for covered services in full when you use a Preferred facility.</p> <p>Member/Non-member: You pay all charges</p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Extended care benefits/Skilled nursing care facility benefits	You Pay	
	Standard Option	Basic Option
<p>Limited to the following benefits for Medicare Part A copayments:</p> <p>When Medicare Part A is the primary payor (meaning that it pays first) and has made payment, Standard Option provides limited secondary benefits.</p> <p>We pay the applicable Medicare Part A copayments incurred in full during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare’s special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases.</p> <p>If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day.</p> <p>Note: See page 43 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs.</p> <p>Note: If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.</p>	<p>Preferred: Nothing</p> <p>Participating/Member: Nothing</p> <p>Non-participating/Non-member: Nothing</p> <p>Note: You pay all charges not paid by Medicare after the 30th day.</p>	<p><i>All charges</i></p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Hospice care	You Pay	
	Standard Option	Basic Option
<p>Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six (6) months or less due to a terminal medical condition, as certified by the member’s primary care provider or specialist.</p>	See below and pages 78-79	See below and pages 78-79
<p>Pre-Hospice Enrollment Benefits</p> <p>Prior approval is not required.</p> <p>Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as:</p> <ul style="list-style-type: none"> • Evaluating the member’s need for pain and/or symptom management; and • Counseling regarding hospice and other care options 	Nothing	Nothing
<p>Prior approval from the Local Plan is required for all hospice services. Our prior approval decision will be based on the medical necessity of the hospice treatment plan and the clinical information provided to us by the primary care provider (or specialist) and the hospice provider. We may also request information from other providers who have treated the member. All hospice services must be billed by the approved hospice agency. You are responsible for making sure the hospice care provider has received prior approval from the Local Plan (see page 16 for instructions). Please check with your Local Plan and/or your PPO directory for listings of Preferred hospice providers.</p> <p>Note: If Medicare Part A is the primary payor for the member’s hospice care, prior approval is not required. However, our benefits will be limited to those services listed above and on pages 78 and 79.</p> <p>Members with a terminal medical condition (or those acting on behalf of the member) are encouraged to contact the Case Management Department at their Local Plan for information about hospice services and Preferred hospice providers.</p>		

Hospice care – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Hospice care <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Covered services</p> <p>We provide benefits for the hospice services listed below when the services have been included in an approved hospice treatment plan and are provided by the home hospice program in which the member is enrolled:</p> <ul style="list-style-type: none"> • Nursing care • Periodic physician visits • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Oxygen therapy • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency) 	See below	See below
<p>Traditional Home Hospice Care</p> <p>Periodic visits to the member’s home for the management of the terminal medical condition and to provide limited patient care in the home. See page 77 for prior approval requirements.</p>	Nothing	Nothing
<p>Continuous Home Hospice Care</p> <p>Services provided in the home to members enrolled in home hospice during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member’s condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).</p> <p>Note: Members must receive prior approval from the Local Plan for each episode of continuous home hospice care (see page 77). An episode consists of up to seven (7) consecutive days of continuous care. Each episode must be separated by at least 21 days of traditional home hospice care. The member must be enrolled in a home hospice program and the continuous home hospice care services must be provided by the home hospice program in which the member is enrolled.</p>	<p>Preferred: \$200 per episode copayment</p> <p>Member: \$350 per episode copayment</p> <p>Non-member: \$350 per episode copayment, plus 35% of the Plan allowance and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 maximum per episode</p> <p>Member/Non-member: You pay all charges</p>

Hospice care – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Hospice care (continued)	You Pay	
	Standard Option	Basic Option
<p>Inpatient Hospice Care</p> <p>Inpatient care provided on a short-term basis. Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when:</p> <ul style="list-style-type: none"> • Inpatient services are necessary to control pain and/or manage the member’s symptoms; • Death is imminent; or • Inpatient services are necessary to provide an interval of relief (respite) to the caregiver <p>Note: Benefits are provided for up to seven (7) consecutive days in a facility licensed as an inpatient hospice facility. Each inpatient stay must be separated by at least 21 days of traditional home hospice care. The member does not have to be enrolled in a home hospice care program to be eligible for the first inpatient stay. However, the member must be enrolled in a home hospice care program in order to receive benefits for subsequent inpatient stays.</p>	<p>Preferred: \$250 per admission copayment</p> <p>Member: \$350 per admission copayment, plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment, plus 35% of the Plan allowance and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission</p> <p>Member/Non-member: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Homemaker services</i> • <i>Home hospice care (e.g., care given by a home health aide), that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.

Ambulance	You Pay	
	Standard Option	Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p> <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member or Non-participating/Non-member: Nothing (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Wheelchair van services and gurney van services</i> • <i>Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person’s health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does <i>not</i> apply. There is no calendar year deductible under Basic Option.		
Accidental injury	Standard Option	Basic Option
<ul style="list-style-type: none">• Physician services in the hospital outpatient department, urgent care center, or physician’s office, including diagnostic studies, radiology services, laboratory tests, and pathology services• Related outpatient hospital services and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services <p>Note: We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: See Section 5(g) for dental benefits for accidental injuries.</p>	<p>Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p>	<p>Preferred emergency room: \$125 copayment per visit Participating/Member emergency room: \$125 copayment per visit Non-participating/Non-member emergency room: \$125 copayment per visit</p> <p>Note: You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$125 emergency room copayment. However, the \$150 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p> <p>For the following places of service, you must receive care from a Preferred provider:</p> <p>Preferred urgent care center: \$50 copayment per visit Preferred primary care provider or other health care professional’s office: \$25 copayment per visit Preferred specialist’s office: \$35 copayment per visit</p> <p>Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none">• Oral surgery except as shown in Section 5(b)• Injury to the teeth while eating• Emergency room professional charges for shift differentials	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Medical emergency	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> • Physician services in the hospital outpatient department, urgent care center, or physician’s office, including diagnostic studies, radiology services, laboratory tests, and pathology services • Related outpatient hospital services and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services <p>Note: We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: Please refer to Section 3 for information about precertifying emergency hospital admissions.</p>	<p>Preferred emergency room: 15% of the Plan allowance</p> <p>Participating/Member emergency room: 15% of the Plan allowance</p> <p>Non-participating/Non-member emergency room: 15% of the Plan allowance. If you use a Non-participating provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Preferred urgent care center: 15% of the Plan allowance</p> <p>Preferred provider’s office: 15% of the Plan allowance</p> <p>Note: If you receive services in a Preferred physician’s office, you pay a \$20 copayment (\$30 for specialists) (No deductible) for the office visit, and 15% of the Plan allowance for all other services (deductible applies).</p> <p>Participating/Member (for other than emergency room): 35% of the Plan allowance</p> <p>Non-participating/Non-member (for other than emergency room): 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: These benefit levels do not apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on page 82 for the benefits we provide.</p>	<p>Preferred emergency room: \$125 copayment per visit</p> <p>Participating/Member emergency room: \$125 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$125 copayment per visit</p> <p>Note: You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$125 emergency room copayment. However, the \$150 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p> <p>For the following places of service, you must receive care from a Preferred provider:</p> <p>Preferred urgent care center: \$50 copayment per visit</p> <p>Preferred primary care provider or other health care professional’s office: \$25 copayment per visit</p> <p>Preferred specialist’s office: \$35 copayment per visit</p> <p>Participating/Member (for other than emergency room): You pay all charges</p> <p>Non-participating/Non-member (for other than emergency room): You pay all charges</p>

Medical emergency – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Medical emergency (continued)	You Pay	
	Standard Option	Basic Option
<i>Not covered: Emergency room professional charges for shift differentials</i>	<i>All charges</i>	<i>All charges</i>
Ambulance		
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p> <p>Note: See Section 5(c) for non-emergency ambulance services.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services (No deductible)</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services (No deductible)</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day (No deductible).</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p> <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member or Non-participating/Non-member: Nothing (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Wheelchair van services and gurney van services</i> • <i>Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you have a chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to pages 108 and 128. Contact us at the telephone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your health care needs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added “(No deductible)” to show when the deductible does not apply.
 - You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
 - **You must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
 - There is **no calendar year deductible.**

Benefit Description		You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does <i>not</i> apply. There is no calendar year deductible under Basic Option.			
Professional services	Standard Option	Basic Option	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	

Professional services – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Professional services (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Professional services, including individual or group therapy, provided by licensed professional mental health and substance abuse practitioners when acting within the scope of their license</p> <ul style="list-style-type: none"> • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Pharmacotherapy (medication management) • Psychological testing <p>Note: To locate a Preferred provider, consult your online PPO directory by visiting www.fepblue.org, or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.</p> <p>Note: See page 51 for our coverage of smoking and tobacco cessation treatment.</p> <p>Note: See page 38 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy.</p>	<p>Preferred: \$20 copayment for the visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Inpatient professional visits 	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does *not* apply.
 There is no calendar year deductible under Basic Option.

Inpatient hospital or other covered facility	You Pay	
	Standard Option	Basic Option
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Diagnostic tests <p>Note: You must get precertification of inpatient hospital stays; failure to do so will result in a \$500 penalty.</p>	<p>Preferred: \$250 per admission copayment for unlimited days (No deductible)</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (No deductible)</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment (No deductible)</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>
Outpatient hospital or other covered facility		
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Diagnostic tests Psychological testing Partial hospitalization Facility-based intensive outpatient treatment 	<p>Preferred: 15% of the Plan allowance</p> <p>Member: 35% of the Plan allowance</p> <p>Non-member: 35% of the Plan allowance. You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$25 copayment per day per facility</p> <p>Member/Non-member: You pay all charges (except as noted below)</p> <p>Note: For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing.</p>
Not covered		
<ul style="list-style-type: none"> Marital, family, educational, or other counseling or training services Services performed by a noncovered provider Testing and treatment for learning disabilities and mental retardation Applied behavior analysis (ABA) Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs <p>Note: We cover professional services as described on pages 85 and 86 when they are provided and billed by a covered professional provider acting within the scope of his or her license.</p> <ul style="list-style-type: none"> Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.) Light boxes 	All charges	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 90.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 98 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 98 of this Section for more information about this important program.
- **Under Standard Option,**
 - You may use the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program to fill your prescriptions.
 - The calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. We added “(calendar year deductible applies)” when it applies.
 - PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option,**
 - **You must use Preferred providers or the Specialty Drug Pharmacy Program in order to receive benefits. See page 14 for the exceptions to this requirement.** Our specialty drug pharmacy is a Preferred provider.
 - There is **no calendar year deductible**.
 - The Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, through our Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, our Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. See page 134 for the definition of “specialty drugs.”

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy, through a Preferred internet pharmacy, or through the Specialty Drug Pharmacy Program, in order to receive benefits. See page 134 for the definition of “specialty drugs.”

- **We use an open formulary.** This includes a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our preferred drug list.

Under Standard Option, we may ask your doctor to substitute a preferred drug in order to help control costs. If you purchase a drug that is not on our preferred drug list, your cost will be higher. We cover drugs that require a prescription (whether or not they are on our preferred drug list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our preferred drug list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our preferred drug list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our preferred drug list.)

Note: Before filling your prescription, please check the preferred/non-preferred status of your medication. Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year. Prescription drugs are reviewed by the Plan for safety and clinical efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

Tier 1: Includes generic drugs

Tier 2: Includes preferred brand-name drugs

Tier 3: Includes non-preferred brand-name drugs

Tier 4: Includes specialty drugs

You can view our preferred drug list on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

By filling your prescriptions (or those of family members covered by the Plan) at a retail pharmacy, through an internet pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug. Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.**

- **Why use generic drugs?** Generic medications are generally lower cost drugs that have the same active ingredients as their brand-name equivalents. Generic drugs have the same quality and strength as brand-name drugs and must meet the same strict standards for quality and effectiveness set by the U.S. Food and Drug Administration (FDA), as brand-name drugs.

You can save money by using generic drugs. Keep in mind that doctors often have several medication options to treat their patients. If your brand-name drug does not have an equivalent generic drug, there may be another generic drug available to treat your condition. You may want to talk with your doctor about generic drugs and how you can reduce your prescription drug costs. You or your doctor may request a brand-name drug even if a generic option is available.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**

Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail or Specialty Drug Pharmacy Program. You may purchase a supply of **more than 21 days up to 90 days** through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used.** Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Covered medications and supplies

Standard Option Generic Incentive Program

Your cost-share will be waived for the first 4 generic prescriptions filled (and/or refills ordered) per drug per calendar year if you purchase a brand-name drug listed below while a member of the Service Benefit Plan and then change to a corresponding generic drug replacement while still a member of the Plan.

Preferred Retail Pharmacy

- Your 20% coinsurance amount (15% when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 coinsurance waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for your coinsurance amount.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

Mail Service Prescription Drug Program

- Your \$15 copayment (\$10 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 copayment waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for the copayment.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

If you take one of these brand-name drugs . . .	And change to one of these generic drug replacements . . .	<p>You will receive your first 4 prescription fills (or refills) of the corresponding generic drug at no charge.</p> <p>(Please see the Standard Option Generic Incentive Program description above for complete information.)</p>
Actonel, Boniva, Fosamax	alendronate	
Aciphex, Dexilant (formerly Kapidex), Nexium, Prevacid, Prilosec, Protonix, Zegerid	omeprazole, lansoprazole, or pantoprazole	
Ambien CR, Lunesta, Rozerem	zaleplon, zolpidem, or zolpidem extended-release	
Beconase AQ, Nasacort AQ, Nasonex, Omnaris, Rhinocort Aqua, Veramyst	fluticasone or triamcinolone acetonide nasal spray	
Advicor, Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, Simcor, Vytorin, Zocor	simvastatin, pravastatin, or lovastatin	
Caduet	simvastatin, pravastatin, lovastatin, or amlodipine	
Toprol XL	metoprolol SR	
Famvir	famciclovir	
Valtrex	valacyclovir	
Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, Teveten	losartan	
Atacand HCT, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Teveten HCT	losartan HCTZ	
Detrol, Oxytrol, Sanctura, Toviaz, Vesicare	oxybutynin, oxybutynin extended-release, or trospium	
Detrol LA, Enablex, Sanctura XR	oxybutynin extended-release	

Please note the list of eligible generic drug replacements may change if additional generic drugs corresponding to the listed brand-name drugs become available during the year. For the most up-to-date information, please visit our Pharmacy Program Web site through www.fepblue.org.

Covered medications and supplies – continued on next page

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.		
Covered medications and supplies (continued)	Standard Option	Basic Option
<ul style="list-style-type: none">• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase <i>Note:</i> See page 92 for our coverage of medicines to promote better health as recommended under the Affordable Care Act. <i>Note:</i> See Section 5(a), page 48, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.• Insulin and diabetic test strips• Needles and disposable syringes for the administration of covered medications• Clotting factors and anti-inhibitor complexes for the treatment of hemophilia• Drugs to aid smoking and tobacco cessation that require a prescription by Federal law <i>Note:</i> We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 96. <i>Note:</i> You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 96 for more information.• Contraceptive drugs and devices, limited to:<ul style="list-style-type: none">– Depo-Provera– Diaphragms and contraceptive rings– Intrauterine devices (IUDs)– Implantable contraceptives– Oral and transdermal contraceptives<i>Note:</i> See <i>Family planning</i> in Section 5(a).• Drugs for the diagnosis and treatment of infertility, except as described on page 99	See page 90 and pages 92-97	See page 90 and pages 92-97

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Routine immunizations when provided by a Preferred retail pharmacy that participates in our vaccine network (see below) and administered in compliance with applicable state law and pharmacy certification requirements, limited to:</p> <ul style="list-style-type: none"> • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines • Influenza (flu) vaccines • Pneumococcal vaccines • Meningococcal vaccines <p>Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more of the routine immunizations listed above. Check with your pharmacy or call our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) to see which vaccines your pharmacy can provide.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges (except as noted below)</p> <p>Note: You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges (except as noted below)</p> <p>Note: You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.</p>
<p>Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”), limited to:</p> <ul style="list-style-type: none"> • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women capable of pregnancy • Aspirin for men age 45 through 79 and women age 55 through 79 <p>Note: Benefits are not available for <i>Tylenol</i>, <i>Ibuprofen</i>, <i>Aleve</i>, etc.</p> <p>Note: Benefits for the medicines listed above are subject to the dispensing limitations described on page 89 and are limited to recommended prescribed limits.</p> <p>Note: To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist.</p> <p>Note: A complete list of the preventive care services recommended under the Affordable Care Act is available online at: www.healthcare.gov/law/about/provisions/services/lists.html. Services recommended under the Act and guidelines for health plan coverage are subject to Federal regulations.</p> <p>Note: See page 96 for our coverage of smoking and tobacco cessation medicines.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Here is how to obtain your prescription drugs and supplies:</p> <p>Preferred Retail Pharmacies</p> <ul style="list-style-type: none"> • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit our Web site, www.fepblue.org, select the “Pharmacy” page, and click on the “Retail Pharmacy” link for your enrollment option (Standard or Basic) to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org <p>Note: Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies.</p> <p>Note: For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained prescription drugs, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to page 94.</p> <p>Note: For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077).</p> <p>Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.</p>	<p>Tier 1 (generic drug): 20% of the Plan allowance</p> <p>Note: You pay 15% of the Plan allowance when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 90 for complete information.</p> <p>Tier 2 (preferred brand-name drug): 30% of the Plan allowance</p> <p>Tier 3 (non-preferred brand-name drug): 45% of the Plan allowance</p> <p>Tier 4 (specialty drug): 30% of the Plan allowance</p> <p>Note: If you use the Specialty Drug Pharmacy Program, you pay an \$80 copayment for the first 30 specialty prescriptions filled (and/or refills ordered) per calendar year; and \$50 per prescription/refill thereafter. See page 95 for more information.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name coinsurance amount when you receive a brand-name drug.</p> <p>Note: When a generic equivalent becomes available, we may classify the Tier 2 brand-name drug as a Tier 3 brand-name drug in determining how much you pay for the drug.</p>	<p>First-time purchase of a new prescription up to a 34-day supply:</p> <p>Tier 1 (generic drug): \$10 copayment</p> <p>Tier 2 (preferred brand-name drug): \$40 copayment</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$50 minimum)</p> <p>Tier 4 (specialty drug): \$50 copayment</p> <p>Refills or continuing prescriptions up to a 90-day supply:</p> <p>Tier 1 (generic drug): \$10 copayment for each purchase of up to a 34-day supply (\$30 copayment for 90-day supply)</p> <p>Tier 2 (preferred brand-name drug): \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply)</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$50 minimum for each purchase of up to a 34-day supply, or \$150 minimum for 90-day supply)</p> <p>Tier 4 (specialty drug): \$50 copayment for each purchase of up to a 34-day supply (\$150 copayment for 90-day supply)</p> <p>Note: If you use the Specialty Drug Pharmacy Program, you pay a \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply). See page 95 for more information.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: When a generic equivalent becomes available, we may classify the Tier 2 brand-name drug as a Tier 3 brand-name drug in determining how much you pay for the drug.</p> <p>Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
Non-preferred Retail Pharmacies	<p>45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount</p> <p>Note: If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>	<p><i>All charges</i></p>
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. Note: Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program. (However, the Specialty Drug Pharmacy Program delivers your covered specialty medication directly to you or your doctor's office. See page 95 for more information.) Note: When you use a retail pharmacy or our specialty drug pharmacy to purchase a drug that is not available through the Mail Service Program, you pay the applicable retail or specialty pharmacy cost-share amount. (See above and page 93 for retail pharmacy purchases and page 95 for specialty drug pharmacy purchases.)	<p>Mail Service Program:</p> <p>Tier 1 (generic drug): \$15 copayment</p> <p>Note: You pay a \$10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 90 for complete information.</p> <p>Tier 2 (preferred brand-name drug): \$70 copayment</p> <p>Tier 3 (non-preferred brand-name drug): \$95 copayment</p> <p>Note: The copayment amounts listed above for brand-name drugs only apply to your first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; you pay a \$50 copayment per brand-name prescription/refill thereafter.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.</p>	<p>No benefit</p> <p>Note: You may request home delivery of your internet prescription drug purchases. See page 93 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.</p> <p>Note: The Specialty Drug Pharmacy Program delivers specialty medications directly to you or your doctor's office. See page 95 for more information about this program.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Specialty Drug Pharmacy Program</p> <p>We cover specialty drugs that are listed on the Service Benefit Plan Specialty Drug List. (See page 134 for the definition of “specialty drugs.”)</p> <p>If your doctor orders more than a 21-day supply of covered specialty drugs, up to a 90-day supply, you can use this service for your prescriptions and refills.</p> <p>Note: If your specialty drug order is for 21 days or less, please call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549) for assistance.</p> <p>Please refer to Section 7 for instructions on using the Specialty Drug Pharmacy Program.</p> <p>Please note the list of covered specialty drugs is subject to change. For the most up-to-date listing, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our Web site, www.fepblue.org.</p>	<p>Specialty Drug Pharmacy Program:</p> <p>Tier 4 (specialty drug): \$80 for first 30 prescriptions filled (and/or refills ordered) per calendar year; \$50 per prescription/refill thereafter</p>	<p>Specialty Drug Pharmacy Program:</p> <p>Tier 4 (specialty drug): \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply)</p> <p>Note: You must fill your prescriptions at our specialty drug pharmacy or a Preferred retail pharmacy in order to receive benefits. Specialty drugs filled at our specialty drug pharmacy will be reimbursed at the higher level of benefits.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Smoking and Tobacco Cessation Medications</p> <p>If you are age 18 or over, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred Retail Pharmacy.</p> <p>To qualify, complete the Blue Health Assessment questionnaire and/or answer the initial consultation questions in the Breathe Module for smoking cessation on Blue Health Connection (BHC). For more information about the Blue Health Assessment questionnaire and the Breathe Module, see pages 106-107.</p> <p>The following medications are covered through this program:</p> <ul style="list-style-type: none"> • Generic medications available by prescription: <ul style="list-style-type: none"> – Bupropion ER 150 mg tablet – Bupropion SR 150 mg tablet • Brand-name medications available by prescription: <ul style="list-style-type: none"> – Chantix 0.5 mg tablet – Chantix 1 mg cont monthly pack – Chantix 1 mg tablet – Chantix starting monthly pack – Nicotrol cartridge inhaler – Nicotrol NS Spray 10 mg/ml • Over-the-counter (OTC) medications <p>Note: To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred Retail pharmacy.</p> <p>Note: These benefits apply only when all of the criteria listed above are met. Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above.</p> <p>Note: See page 51 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
Drugs from other sources <ul style="list-style-type: none"> Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program <p>Note: Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription.</p> <p>Note: For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services.</p> <ul style="list-style-type: none"> Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: <ul style="list-style-type: none"> Physician's office – Section 5(a) Hospital (inpatient or outpatient) – Section 5(c) Hospice agency – Section 5(c) Please refer to page 93 for retail pharmacy-obtained prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility 	<p>Preferred: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Participating/Member: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating/Non-member: 35% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Member or Non-participating/Non-member: You pay all charges</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Patient Safety and Quality Monitoring (PSQM)</p> <p>We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:</p> <ul style="list-style-type: none"> • Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them. • Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. <p>For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).</p> <p>Prior Approval</p> <p>As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage. In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval.</p> <p>Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>		

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Medical supplies such as dressings and antiseptics • Drugs and supplies for cosmetic purposes • Drugs and supplies for weight loss • Drugs for orthodontic care, dental implants, and periodontal disease • Drugs used in conjunction with assisted reproductive technology (ART) procedures • Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law <p>Note: See page 92 for our coverage of medicines recommended under the Affordable Care Act and page 96 for smoking and tobacco cessation medications.</p> <p>Note: See Section 5(a), page 48, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.</p> <ul style="list-style-type: none"> • Drugs for which prior approval has been denied or not obtained • Infant formula other than described on page 48 • Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy • Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States 	All charges	All charges

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*, for additional information.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Note:** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.
- **Under Standard Option,**
 - The calendar year deductible applies only to the accidental injury benefit below. We added “(calendar year deductible applies)” when it applies.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**

Accidental injury benefit	You Pay	
	Standard Option	Basic Option
<p>We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.</p> <p>Note: An accidental injury is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries.</p> <p>Note: A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.</p>	<p>Preferred: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Participating: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.</p>	<p>\$25 copayment per visit</p> <p>Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers. See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>

Dental benefits – continued on next page

Dental benefits
What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 105.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, refer to the Preferred Provider Directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only	
Covered service	We pay	You pay
Clinical oral evaluations	<u>To age 13</u>	<u>Age 13 and over</u>
Periodic oral evaluation*	\$12	\$8
Limited oral evaluation	\$14	\$9
Comprehensive oral evaluation	\$14	\$9
Detailed and extensive oral evaluation	\$14	\$9
*Limited to two per person per calendar year		<p>All charges in excess of the scheduled amounts listed to the left</p> <p>Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).</p>

Dental benefits – continued on next page

Standard Option Only

Standard Option dental benefits <i>(continued)</i>		Standard Option Only	
Covered service	We pay		You pay
Radiographs	<u>To age 13</u>	<u>Age 13 and over</u>	<p>All charges in excess of the scheduled amounts listed to the left</p> <p>Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).</p>
Intraoral complete series	\$36	\$22	
Intraoral periapical first film	\$7	\$5	
Intraoral periapical each additional film	\$4	\$3	
Intraoral occlusal film	\$12	\$7	
Extraoral first film	\$16	\$10	
Extraoral each additional film	\$6	\$4	
Bitewing – single film	\$9	\$6	
Bitewings – two films	\$14	\$9	
Bitewings – four films	\$19	\$12	
Bitewings – vertical	\$12	\$7	
Posterior-anterior or lateral skull and facial bone survey film	\$45	\$28	
Panoramic film	\$36	\$23	
Tests and laboratory exams			
Pulp vitality tests	\$11	\$7	
Palliative treatment			
Palliative (emergency) treatment of dental pain – minor procedure	\$24	\$15	
Sedative filling	\$24	\$15	
Preventive			
Prophylaxis – adult*	---	\$16	
Prophylaxis – child*	\$22	\$14	
Topical application of fluoride (prophylaxis not included) – child	\$13	\$8	
Topical application of fluoride (prophylaxis not included) – adult	---	\$8	
*Limited to two per person per calendar year			

Dental benefits – continued on next page

Standard Option Only

Standard Option dental benefits <i>(continued)</i>		Standard Option Only	
Covered service	We pay		You pay
Space maintenance (passive appliances)	<u>To age 13</u>	<u>Age 13 and over</u>	<p>All charges in excess of the scheduled amounts listed to the left</p> <p>Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).</p>
Space maintainer – fixed – unilateral	\$94	\$59	
Space maintainer – fixed – bilateral	\$139	\$87	
Space maintainer – removable – unilateral	\$94	\$59	
Space maintainer – removable – bilateral	\$139	\$87	
Recementation of space maintainer	\$22	\$14	
Amalgam restorations (including polishing)			
Amalgam – one surface, primary or permanent	\$25	\$16	
Amalgam – two surfaces, primary or permanent	\$37	\$23	
Amalgam – three surfaces, primary or permanent	\$50	\$31	
Amalgam – four or more surfaces, primary or permanent	\$56	\$35	
Filled or unfilled resin restorations			
Resin – one surface, anterior	\$25	\$16	
Resin – two surfaces, anterior	\$37	\$23	
Resin – three surfaces, anterior	\$50	\$31	
Resin – four or more surfaces or involving incisal angle (anterior)	\$56	\$35	
Resin-based composite – one surface, posterior	\$25	\$16	
Resin-based composite – two surfaces, posterior	\$37	\$23	
Resin-based composite – three surfaces, posterior	\$50	\$31	
Resin-based composite – four or more surfaces, posterior	\$50	\$31	
Inlay restorations			
Inlay – metallic – one surface	\$25	\$16	
Inlay – metallic – two surfaces	\$37	\$23	
Inlay – metallic – three or more surfaces	\$50	\$31	
Inlay – porcelain/ceramic – one surface	\$25	\$16	
Inlay – porcelain/ceramic – two surfaces	\$37	\$23	
Inlay – porcelain/ceramic – three or more surfaces	\$50	\$31	

Dental benefits – continued on next page

Standard Option Only

Standard Option dental benefits <i>(continued)</i>			
Covered service	Standard Option Only		
	We pay		You pay
Inlay restorations – continued	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Inlay – composite/resin – one surface	\$25	\$16	
Inlay – composite/resin – two surfaces	\$37	\$23	
Inlay – composite/resin – three or more surfaces	\$50	\$31	
Other restorative services			
Pin retention – per tooth, in addition to restoration	\$13	\$8	
Extractions – includes local anesthesia and routine post-operative care			
Extraction, erupted tooth or exposed root	\$30	\$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$43	\$27	
Surgical removal of residual tooth roots (cutting procedure)	\$71	\$45	
General anesthesia in connection with covered extractions	\$43	\$27	
<i>Not covered: Any service not specifically listed above</i>	<i>Nothing</i>	<i>Nothing</i>	<i>All charges</i>

Dental benefits – continued on next page

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a \$25 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred Provider Directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits		Basic Option Only	
Covered service		We pay	You pay
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year		Preferred: All charges in excess of your \$25 copayment Participating/Non-participating: Nothing	Preferred: \$25 copayment per evaluation Participating/Non-participating: You pay all charges
Radiographs Intraoral – complete series including bitewings (<i>limited to 1 complete series every 3 years</i>) Bitewing – single film* Bitewings – two films* Bitewings – four films* *Benefits are limited to a combined total of 4 films per person per calendar year			
Preventive Prophylaxis – adult (<i>up to 2 per calendar year</i>) Prophylaxis – child (<i>up to 2 per calendar year</i>) Topical application of fluoride (prophylaxis not included) – child (<i>up to 2 per calendar year</i>) Sealant – per tooth, first and second molars only (<i>once per tooth for children up to age 16 only</i>)			
Not covered: Any service not specifically listed above		Nothing	All charges

Section 5(h). Special features

Special feature	Description
Flexible benefits option	<p>Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a flexible benefits option. This option allows professional case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an alternative benefits agreement that includes the terms listed below, in addition to any other terms specified in the agreement.</p> <ul style="list-style-type: none"> • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the alternative benefits agreement, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. <p>If you sign the alternative benefits agreement, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us or circumstances change. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written alternative benefits agreement must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.</p> <p>Note: If we deny a request for precertification or prior approval of regular contract benefits, or if we deny regular contract benefits for services you have already received, you may dispute our denial of regular contract benefits under the OPM disputed claims process (see Section 8).</p>
Blue Health Connection	<p>Stay connected to your health and get the answers you need when you need them by using Blue Health Connection 24 hours a day, 365 days a year. Go to www.fepblue.org or call 1-888-258-3432 toll-free to check out these valuable easy-to-use services:</p> <ul style="list-style-type: none"> • Talk directly with a Registered Nurse any time of the day or night via telephone, secure email, or live chat. Ask questions, get medical advice, or get help determining when to go to see a doctor. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan. • MyBlue Personal Health Record – Access your secure online personal health record for information such as the medications you’re taking, recent test results, and medical appointments. Update, store, and track health-related information at any time. • Blue Health Assessment – Complete this online health and lifestyle questionnaire and receive additional assistance with your health care expenses. See page 107 for complete information. • Breathe™ for Smoking Cessation – Participate in this online smoking cessation program and receive your personalized action plan to quit smoking. Start by completing the Blue Health Assessment questionnaire and the initial consultation portion of the Breathe program. The program will then provide you with an individualized action plan that fits your life, your needs, and your goals. Once you complete the consultation portion of the Breathe program, you will qualify to receive certain smoking and tobacco cessation medications at no charge. See page 96 for more information. • My Multimedia Health Library offers an extensive variety of educational tools using videos, recorded messages, and colorful online material that provide up-to-date information about a wide range of health-related topics. • MyBlue Benefit Statements – Access quarterly and annual statements of recent medical and pharmacy claims and out-of-pocket costs for each family member.

Special features – continued on next page

Blue Health Assessment	<p>The Blue Health Assessment questionnaire is a quick and easy online health evaluation program. Your Blue Health Assessment answers are evaluated to create a unique health action plan. You can also participate in online health programs that can help you reach your health goals in areas such as physical activity, overcoming insomnia, nutrition, weight management, overcoming back pain, stress management, help with depression, and smoking cessation (see Breathe™ for Smoking Cessation on page 106).</p> <p>When you complete your Blue Health Assessment questionnaire, you are entitled to receive a \$35 health account to be used for most qualified medical expenses. For those with Self and Family coverage, up to two (2) adult members, age 18 or over, will be eligible for the \$35 health account. We will send each eligible member a debit card to access his or her health account. Please retain your card for future use even if you have used your health account dollars as you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited.</p> <p>In addition to the \$35 health account, you are entitled to receive up to an additional \$15 for completing up to three (3) online coaching modules through Blue Health Connection. For each module completed, you will receive an additional \$5 credit to your health account. This means that you are eligible to receive up to a maximum of \$50 in your health account for the calendar year. (Please note that the \$5 credit does not apply to completion of the Breathe™ for Smoking Cessation module.)</p> <p>Visit our Web site, www.fepblue.org, for more information and to complete the questionnaire and modules, and receive your individualized results. You may also request a printed Blue Health Assessment questionnaire by calling 1-888-258-3432 toll-free.</p>
Diabetes Management Incentive Program	<p>The Diabetes Management Incentive Program is designed to provide critical health education to people with diabetes, to help assist people with diabetes in improving their blood sugar control, and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of \$75 toward a health account to be used for most qualified medical expenses. To qualify for the Diabetes Management Incentive Program, you must be age 18 or over and complete either the Blue Health Assessment (BHA) questionnaire indicating you have diabetes or the initial questionnaire of the Care™ for Diabetes coaching module available online via the Blue Health Connection Web site. For those with Self and Family coverage, this incentive program is limited to two (2) adult members.</p> <p>The following activities are rewarded through this program:</p> <ul style="list-style-type: none"> • \$10 for having your A1c test performed by a covered provider (maximum of 2 per year) • \$5 for reporting A1c levels to the Diabetes Management Incentive Program via our Web site, www.fepblue.org (maximum of 2 per year) • \$10 for receiving diabetic glucose test strips through our pharmacy program (maximum of 4 per year) • \$10 for receiving a diabetic foot exam from a covered provider (maximum of 1 per year) <p>You can also receive a maximum of 1 of the following 3 rewards:</p> <ul style="list-style-type: none"> • \$20 for enrolling in a diabetes disease management program (maximum of 1 per year) • \$20 for receiving a diabetic education visit from a covered provider (maximum of 1 per year) • \$5 for completing a web-based diabetes education quiz on our Web site, www.fepblue.org (maximum of 4 per year) <p>Note: Once you earn the maximum of \$75 through this program for the calendar year, additional eligible activities are encouraged but will not be rewarded.</p> <p>Note: For more information about this program, including eligibility and enrollment information, please visit www.fepblue.org or call the number on the back of your Service Benefit Plan ID card.</p>

Special features – continued on next page

MyBlue Customer eService	<p>Visit MyBlue Customer eService at www.fepblue.org to check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and track how you use your benefits. Additional features include:</p> <ul style="list-style-type: none"> • Online EOBs – You can view, download, and print your explanation of benefits (EOB) forms. Simply log onto MyBlue Customer eService via www.fepblue.org and click on the “Medical & Pharmacy Claims” link. From there you can enter the desired date range and select the “EOB” link next to each claim to access your EOB. • Opt Out of Paper EOBs – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs. You can opt out of receiving paper EOBs and access your EOBs exclusively online. From the main menu, select the “EOB Mailing Preference” link and follow the on-screen instructions. • Personalized Messages – Our EOBs provide a wide range of messages just for you and your family, ranging from preventive care opportunities to enhancements to our online services!
National Provider Directory	Go to www.fepblue.org to find listings of Preferred providers and pharmacies in our nation-wide Provider Directory.
Care Management Programs	<p>If you have a chronic disease or complex health care needs, the Service Benefit Plan offers members two types of Care Management Programs that provide patient education and clinical support.</p> <ul style="list-style-type: none"> • Case Management: We provide members with complex health care needs with the services of a professional case manager to assess the needs of the member and when appropriate, coordinate, evaluate, and monitor the member's care. • Disease Management: We provide programs to help members adopt effective self-care habits to improve their self-management of diabetes; asthma; chronic obstructive pulmonary disease (COPD); coronary artery disease; congestive heart failure; and certain rare conditions. You may receive information from us regarding the programs available to you in your area. <p>If you have any questions regarding these programs, please contact us at the customer service number on the back of your ID card.</p>
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org , adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Adjust the text size by clicking on the plus (“+”) or minus (“–”) boxes that appear at the top right of every page.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States and Puerto Rico.
Healthy Families Programs	Our Healthy Families suite of programs is for families with children and teens, ages 2-18. The Healthy Kids Program (also called Jump 4 Health) provides printable games, activities, and tools to help parents teach their children about weight management, nutrition, physical activity, and personal wellbeing. The Healthy Teens Program contains a Body Mass Index (BMI) calculator and provides guidance to help parents respond to teen behavior challenges. For more information, go to www.fepblue.org .
WalkingWorks® Wellness Program	<i>WalkingWorks®</i> can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online <i>WalkingWorks</i> tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. <i>WalkingWorks</i> was developed in cooperation with the President’s Council on Physical Fitness and Sports.

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 110 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For professional care you receive overseas, we provide benefits at Preferred benefit levels using a customary percentage of the billed charge as our Plan allowance. **Under Standard Option**, you must pay any difference between our payment and the amount billed, in addition to any applicable deductible, coinsurance, and/or copayment amounts. You must also pay any charges for noncovered services.

Under Basic Option, you pay any difference between our payment and the amount billed, as well as the applicable copayment or coinsurance. You must also pay any charges for noncovered services. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States and Puerto Rico.**

For facility care you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 72-75.

For dental care you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option**, you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option**, you must pay the \$25 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. The Worldwide Assistance Center can help you locate a hospital in our network near where you are staying. You may also view a list of our network hospitals on our Web site, www.fepblue.org. Although we do not have a network of professionals overseas, the Worldwide Assistance Center can also help you locate a physician. You will have to file a claim to us for reimbursement for professional services.

If you are overseas and need assistance locating providers, contact the Worldwide Assistance Center (provided by Mondial Assistance – formerly World Access Service Corporation), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the Virgin Islands should call 1-800-699-4337. Mondial Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- Hospital and physician care

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States and Puerto Rico, send a completed Overseas Claim Form and itemized bills to: Mailroom Administrator, FEP Overseas Claims, P.O. Box 14113, Lexington, KY 40512-4113. We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to this address or call us at 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. You may also obtain Overseas Claim Forms from this address, from our Web site (www.fepblue.org), or from your Local Plan.

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States and Puerto Rico, send a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057, or fax your claim to: 001-480-614-7674. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States or Puerto Rico.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories), and
- The prescribing physician is licensed in the United States or Puerto Rico.

Please see page 94 for more information about using this program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Under Standard and Basic Options, you may order specialty drugs from the Specialty Drug Pharmacy Program only if your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories), and the prescribing physician is licensed in the United States or Puerto Rico. See page 95 for more information about using this program.

Non-FEHB benefits available to Plan members

The benefits on these pages are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Blue365[®]

Blue365[®] is a discount program available to all Service Benefit Plan members that provides resources for healthier living in key areas such as:

- Discounted health club memberships
- Discounts on laser vision correction
- Discounts on hearing aids
- Discounts on diet and weight management programs
- Online information on health-related topics such as nutrition and stress management

With Blue365, there is no paperwork to fill out. All you have to do is visit the designated Web sites to save. Please visit www.fepblue.org to learn more about the various Blue365 vendors and discounts.

The Blue Cross and Blue Shield Service Benefit Plan may receive payments from Blue365 vendors. The Plan does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Discounts on Health Club Memberships

You have access to a network of over 9,000 fitness facilities nationwide. You pay a \$25 initiation fee and \$25 monthly for unlimited visits to network facilities and all amenities included in general membership. You are not limited to a specific facility; you can choose to use any facility that participates in the network. There is a three-month commitment. If you stop participating for two months or more, you will need to pay an additional \$25 initiation fee. Payment can be made by credit card, debit card, or automatic withdrawal. For more information or to enroll, go to www.fepblue.org.

Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual/erectile dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, Staxyn tablet, Viagra tablet, and Yohimbine;

For weight loss: Meridia capsule and Xenical capsule;

For hair removal: Vaniqa cream; *For hair growth:* Propecia;

For skin pigmenting/depigmenting/re-pigmenting: Retinoids [Renova 0.02% (tretinoin) and Avage 0.1% (tazarotene)], Hydroquinone-containing products (Aclaro, Eldoquin Forte, Epiquin Micro, Lustra, Melanex, Melpaque, Nuquin, Obagi Products, Remergent, Solaquin Forte, and Tri-Luma), Monobenzone products (Benoquin), and Tretinoin 0.02%; and

For Miscellaneous: Peridex and Latisse.

Drugs may be added to this list as they are approved by the U.S. Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Vision Care Affinity Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 34,500 providers including optometrists, ophthalmologists, and many retail centers. For a complete description of the program or to find a provider near you, go to www.fepblue.org and click on "Benefit Plans." You may also call us at 1-800-551-3337 between 8:00 a.m. and 11:00 p.m. eastern time, Monday to Friday; 9:00 a.m. to 4:00 p.m. on Saturday; or noon to 4:00 p.m. on Sunday. Please be sure to verify that the provider participates in our Vision Care Affinity Program and ask about the discounts available before your visit, as discounts may vary.

Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the provider's usual fee, or 5% off sales pricing, on laser vision correction procedures. Call 1-800-551-3337 for the nearest location and authorization for the discount.

QualSight® LASIK

QualSight® LASIK offers a nationwide network of credentialed ophthalmologists at over 800 locations in order to provide easy and convenient access for members. Your savings represent 40% to 50% off the overall national average price of traditional LASIK. Significant savings are also provided on newer technologies such as Custom LASIK and bladeless IntraLase. Call 1-877-358-9327 for your free consultation and to see if you are a candidate for one of these procedures.

QualSight LASIK Pricing per Procedure (per eye)*

Traditional LASIK ^{1,2}	\$ 895
Traditional LASIK ^{1,2} and Lifetime Assurance Plan	\$1,295
Traditional LASIK with IntraLase ²	\$1,345
Traditional LASIK with IntraLase ² and Lifetime Assurance Plan	\$1,695
Custom Refractive LASIK ^{1,2}	\$1,320
Custom LASIK ^{1,2} with Lifetime Assurance Plan	\$1,595
Custom LASIK with IntraLase ²	\$1,770
Custom LASIK with IntraLase ² and Lifetime Assurance Plan	\$1,995
Conductive Keratoplasty (CK) ²	\$ 995

¹ Pricing includes all FDA-approved procedures (with no additional charges for astigmatism or higher amounts of correction) and surface ablation procedures (PRK, LASEK, Epi-LASIK) as necessary, and as offered at individual network practices.

Pricing does not include any required prescription or over-the-counter drugs.

² When offered by participating network providers. *A small percentage of providers may charge more for certain procedures, resulting in a higher fee for the procedure. You will be notified of any additional amount prior to scheduling your pre-operative examination with these providers.*

**Provider participation may vary.*

ARAG® Legal Center

Members have access to The Education Center which offers a collection of legal tools and resources that provide helpful tips and simple explanations for complex legal terms and scenarios, as well as guidance on where to turn for more information and assistance. The center includes a secure Personal Information Organizer, a law guide, videos, and an e-newsletter. Visit www.fepblue.org to access this free service and select the ARAG Legal Center link.

DIY Docs™

Members also have the opportunity to purchase a **DIY Docs™** package for a low annual subscription rate of \$69.95 (30% off the \$99 retail rate). DIY Docs members receive access to more than 300 legally-valid documents. These documents are authored and reviewed by attorneys for accuracy and to ensure they are legally valid in all 50 states. Available DIY Docs include a Will, Living Will, Powers of Attorney, Medical Authorization for a Minor, Bill of Sale, Contract, Residential Lease, and much more.

The DIY Docs package includes an easy-to-use document assembly tool that walks a member through an interview process, with answers resulting in the completed document. DIY Docs is available online 24 hours a day, 365 days a year, and provides secure storage to create, update, and print documents at any time. For more information or to purchase DIY Docs, visit www.fepblue.org and select the ARAG Legal Center link.

SNAPforSeniors®

SNAPforSeniors® (Search New Available Places) simplifies the difficult process of finding appropriate senior housing options by providing members with the Senior Housing Locator – an online tool to access a current, comprehensive database of more than 60,000 senior housing communities. By using the Senior Housing Locator, you can search for assisted living communities, residential care, nursing homes, continuing care retirement communities, and independent living communities anywhere in the nation. You can also find information about the qualifications of listed nursing homes, such as licensure and Medicare certification, to help you with your decision. You can personalize your housing choices to best match the services and amenities available in each community to your lifestyle and health needs. Visit the Senior Housing Locator via www.fepblue.org.

Federal DentalBlue

Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. Federal DentalBlue is available to members who reside in Alabama, Illinois, New Mexico, Oklahoma, or Texas. To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your local Blue Cross and Blue Shield Plan. For more information, please contact us at:

Alabama: 1-800-492-8872 or www.bcbsal.org

Illinois: 1-866-431-1595 or www.yourfederaldental.com

New Mexico: 1-866-431-1604 or www.yourfederaldental.com

Oklahoma: 1-866-431-1602 or www.yourfederaldental.com

Texas: 1-866-431-1598 or www.yourfederaldental.com

Section 6. General exclusions – things we don’t cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 (*You need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events (see definition on page 131).
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 25), doctor’s charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 26), or State premium taxes however applied.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 12.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of morbid obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures (see page 53); and those nutritional counseling services specifically listed on pages 31, 35, 37, and 70.
- Services you receive from a provider that are outside the scope of the provider’s licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*.
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.
- Services of standby physicians.
- Self-care or self-help training.
- Custodial care.
- Personal comfort items such as beauty and barber services, radio, television, or telephone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under Preventive care, adult and child in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 34-37 and 72; and certain routine services associated with covered clinical trials (see page 127).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA).
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for shift differentials.
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring precertification or prior approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment, home nursing care, or physical, occupational, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for dental care to repair accidental injury to sound natural teeth should include documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, through the Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See pages 116-117 for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.)

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our Web site, www.fepblue.org, visit the “Pharmacy” page, and click on the “Retail Pharmacy” link for your enrollment option (Standard or Basic) to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 16).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

- (1) Complete the initial mail order form;
- (2) Enclose your prescription and copayment;
- (3) Mail your order to CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590; and
- (4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Note: Specialty drugs will not be dispensed through the Mail Service Prescription Drug Program. See page 117 for information about the Specialty Drug Pharmacy Program.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Specialty Drug Pharmacy Program

Standard and Basic Options: If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will deliver your specialty medication directly to you or your doctor's office in about two weeks. After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our Web site, www.fepblue.org.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 109 and 110 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process **if you disagree with our decision on your post-service claim** (a claim where services, drugs, or supplies have already been provided). In Section 3, ***If you disagree with our pre-service claim decision***, we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may be able to appeal directly to the U.S. Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please visit www.fepblue.org.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
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| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
|----------|---|

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.

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| 2 | <p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim orWrite to you and maintain our denial orAsk you or your provider for more information. <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.</p> |
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| 3 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information. |
|----------|--|

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street, NW, Washington, DC 20415-3610.

The disputed claims process (*continued*)

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service number on the back of your Service Benefit Plan ID card. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor’s benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payor (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan’s copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan’s payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 123.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778), to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you do not have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 25 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 15 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When the Original Medicare Plan is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
 - Inpatient hospital per-admission copayments; and
 - Inpatient Member and Non-member hospital coinsurance.
- Under **Basic Option**, we will waive our:
 - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
 - Calendar year deductible;
 - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
 - Copayments for office visits to Preferred physicians and other health care professionals;
 - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
 - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
 - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You can find more information about how our Plan coordinates benefits with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 14 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you – or your covered spouse – are age 65 or over and have Medicare and you . . .	The primary payor for the individual with Medicare is . . .	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and . . .		
<ul style="list-style-type: none"> You have FEHB coverage on your own or through your spouse who is also an active employee You have FEHB coverage through your spouse who is an annuitant 	✓	✓
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member . . .		
1) Have Medicare solely based on end stage renal disease (ESRD) and . . .		
<ul style="list-style-type: none"> It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD 	✓	✓
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and . . .		
<ul style="list-style-type: none"> This Plan was the primary payor before eligibility due to ESRD (for the 30-month coordination period) Medicare was the primary payor before eligibility due to ESRD 	✓	✓
3) Have Temporary Continuation of Coverage (TCC) and . . .		
<ul style="list-style-type: none"> Medicare based on age and disability Medicare based on ESRD (for the 30-month coordination period) Medicare based on ESRD (after the 30-month coordination period) 	✓	✓
C. When either you or a covered family member are eligible for Medicare solely due to disability and you . . .		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

* Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, “you” includes your covered dependents, and “your representatives” include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not “made whole” for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney’s fees and costs under the “common fund” or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys’ fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced, at the Carrier’s option, by the Carrier, by any of the Local Plans that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
 - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
 - Uninsured and underinsured motorist coverage
 - Workers’ Compensation benefits
 - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Clinical Trials

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

If you are a participant in a clinical trial, this health Plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan at the benefit levels described in Section 5 (*Benefits*) when the associated services are determined to be medically necessary and within the contractual provisions of the Plan.
- Extra care costs – costs of covered services related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. This Plan covers extra care costs related to taking part in an approved clinical trial for a covered stem cell transplant such as additional tests that a patient may need as part of the clinical trial protocol, but not as part of the patient’s routine care. For more information about approved clinical trials for covered stem cell transplants, see pages 63-64. Extra care costs related to taking part in any other type of clinical trial are not covered. We encourage you to contact us at the customer service number on the back of your ID card to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Accidental injury	An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. Note: Injuries to the teeth while eating are not considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.
Admission	The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.
Agents	Medicines and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medicines and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT Scans, MRIs, PET Scans, lung scans, and X-rays, as well as those injected into the joint.
Assignment	An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Carrier	The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.
Case management	A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2002). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC or NCQA. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.
Clinical trials cost categories	<ul style="list-style-type: none">• Routine care costs – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.
Concurrent care claims	A claim involving care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. See pages 17 and 18 in Section 3.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 20.
Cosmetic surgery	Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 20.

Diagnostic service

An examination or test of an individual with signs, symptoms, or a probability of having a specific disease to determine the presence of that disease; or an examination or test to evaluate the course of treatment for a specific disease.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

Experimental or investigational shall mean:

- a. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and approval for marketing has not been given at the time it is furnished; or
- b. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- c. Reliable evidence shows that the consensus of opinion among experts regarding the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- d. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

Reliable evidence shall mean only evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations, such as:

- a. Published reports and articles in the authoritative medical and scientific literature;
- b. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- c. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Group health coverage	Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than \$200 per day for hospitalization (including extension of any of these benefits through COBRA).
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Health Risk Assessment (HRA)	A questionnaire designed to assess your overall health and identify potential health risks. Service Benefit Plan members have access to the Blue Cross and Blue Shield HRA (called the “Blue Health Assessment”) which is supported by a computerized program that analyzes your health and lifestyle information and provides you with a personal and confidential health action plan that is protected by HIPAA privacy and security provisions. Results from the Blue Health Assessment include practical suggestions for making healthy changes and important health information you may want to discuss with your health care provider. For more information, visit our Web site, www.fepblue.org .
Intensive outpatient care	A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.
Local Plan	A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.
Medical foods	The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.
Medical necessity	<p>All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:</p> <ul style="list-style-type: none"> a. In accordance with generally accepted standards of medical practice in the United States; and b. Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient’s illness, injury, disease, or its symptoms; and c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient’s illness, injury, or disease, or its symptoms; and d. Not part of or associated with scholastic education or vocational training of the patient; and e. In the case of inpatient care, only provided safely in the acute inpatient hospital setting. <p>For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.</p> <p>The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.</p>

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Never Events

Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.

Observation services

Hospital outpatient services ordered by the physician to assess whether the member needs to be admitted as an inpatient or can be discharged. If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services – including “**observation services**” – are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers** – Our allowance (which we may refer to as the “PPA” for “Preferred Provider Allowance”) is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with CVS Caremark) have agreed to accept as payment in full, when we pay primary benefits.

Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the “Preferred rate.” The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 101 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers** – Our allowance (which we may refer to as the “PAR” for “Participating Provider Allowance”) is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the “Member rate.” The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.

- **Non-participating providers** – We have no agreements with these providers to limit what they can bill you for their services. **This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive.** We determine our allowance as follows:
 - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;
 - For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is the average amount for all outpatient surgical claims combined that we pay nationally to contracting and non-contracting facilities. This allowance applies to all of the covered surgical services billed by the hospital and is the same regardless of the type of surgery performed. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient surgical procedure, please call us before your surgery at the customer service number on the back of your ID card to obtain the current allowed amount and assistance in estimating your total out-of-pocket expenses.

Please keep in mind that Non-member facilities may bill you for any difference between the allowance and the billed amount. You may be able to reduce your out-of-pocket expenses by using a Preferred hospital for your outpatient surgical procedure. To locate a Preferred provider, refer to our online Provider Directory at www.fepblue.org or call us at the customer service number on the back of your ID card;

- For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the billed amount (minus any amounts for noncovered services);
- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the current year’s Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the “NPA” (for “Non-participating Provider Allowance”);
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greatest of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained; or 2) 100% of the current year’s Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained; or 3) an allowance based on equivalent Preferred provider services that is calculated in compliance with the Affordable Care Act;
- For prescription drugs furnished by retail and internet pharmacies that do not contract with CVS Caremark, our allowance is the average wholesale price (“AWP”) of a drug on the date it is dispensed, as set forth by Medi-Span[®] in its national drug data file; and
- For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with Mondial Assistance, our allowance is a customary percentage of the billed charge.

Important notice about Non-participating providers!

Note: Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive. Non-participating and Non-member providers are under no obligation to accept our allowance as payment in full. If you use Non-participating and/or Non-member providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances involving covered Non-participating professional care – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment. You can reduce your out-of-pocket expenses by using Preferred providers whenever possible. To locate a Preferred provider, refer to our online Provider Directory at www.fepblue.org or call us at the customer service number on the back of your ID card. We encourage you to always use Preferred providers for your care.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than \$5,000 for an episode of care, your responsibility will be limited to \$5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive during an emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services), plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as a radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or pediatric sub-specialist; and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providers in a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 82-83).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see page 23 and pages 109-110.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Pre-service claims

Those claims (1) that require precertification or prior approval, and (2) where failure to obtain precertification or prior approval results in a reduction of benefits.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail and internet pharmacies, between pharmacies and CVS Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, CVS Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Preventive Care, Adult	Adult preventive care includes the following services when performed as part of a routine annual physical examination: chest X-ray; EKG; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for alcohol/substance abuse; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, and HIV; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings and screening for abdominal aortic aneurysms as specifically stated in this brochure; and routine immunizations as licensed by the U.S. Food and Drug Administration (FDA).
Prior approval	<p>Written assurance that benefits will be provided by:</p> <ol style="list-style-type: none"> 1. The Local Plan where the services will be performed; or 2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies), the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. <p>For more information, see the benefit descriptions in Section 5 and <i>Other services</i> in Section 3, under <i>You need prior Plan approval for certain services</i>, on pages 15-16.</p>
Routine services	Services that are not related to a specific illness, injury, set of symptoms, or maternity care (other than those routine costs associated with a clinical trial as defined on page 127).
Screening service	An examination or test of an individual with no signs or symptoms of the specific disease for which the examination or test is being done, to identify the potential for that disease and prevent its occurrence.
Sound natural tooth	A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.
Specialty drugs	<p>Pharmaceutical products that are included on the Service Benefit Plan Specialty Drug List that are typically high in cost and have one or more of the following characteristics:</p> <ul style="list-style-type: none"> • Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology • Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects • Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy • Unique patient compliance and safety monitoring requirements • Unique requirements for handling, shipping, and storage
Transplant period	A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our customer service department using the number on the back of your Service Benefit Plan ID card and tell us the claim is urgent. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We/Our

“Us,” “we,” and “our” refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

“You” and “your” refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health benefits coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; and refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money.

Annuitants are not eligible to enroll.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician-prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

Note: If you are enrolled in the HCFSA, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSA without submitting an FSAFEDS claim. When the Blue Cross and Blue Shield Service Benefit Plan receives a claim for benefits, the Plan forwards information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs – there's no need for a claim form or receipt! Reimbursement is made directly to your bank from your HCFSA account via Electronic Funds Transfer. You may need to file a paper claim to FSAFEDS in certain situations. Visit www.FSAFEDS.com for more information. FSAFEDS is not part of the Service Benefit Plan.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time.
TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program – PCIP

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool, then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 per person (\$700 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; 15%* of our allowance; \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists Non-PPO: 35%* of our allowance	31-32
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: \$250 per admission Non-PPO: \$350 per admission, plus 35% of our allowance	69-71
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	72-75
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	81-82
<ul style="list-style-type: none"> Medical emergency 	PPO and Non-PPO: 15%* of our allowance for emergency room care; Regular benefits for physician and hospital care* provided in settings other than the emergency room Ambulance transport services: \$100 per day for ground ambulance (no deductible); \$150 per day for air or sea ambulance (no deductible)	81, 83-84
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$20 office visit copay; \$250 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; \$350 per inpatient admission, plus 35% of our allowance	85-87
Prescription drugs	Retail Pharmacy Program: <ul style="list-style-type: none"> PPO: 20% of our allowance generic (15% if you have Medicare)/30% of our allowance preferred brand-name/45% of our allowance non-preferred brand-name/30% of our allowance specialty; up to a 90-day supply Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program: <ul style="list-style-type: none"> \$15 generic (\$10 if you have Medicare)/\$70 preferred brand-name/\$95 non-preferred brand-name per prescription; up to a 90-day supply Specialty Drug Pharmacy Program: <ul style="list-style-type: none"> \$80 per prescription; up to a 90-day supply 	88-99
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	57, 100-104
Special features: Flexible benefits option; Blue Health Connection; Blue Health Assessment; Diabetes Management Incentive Program; MyBlue Customer eService; national provider directory; care management programs; travel benefit/services overseas; Healthy Families Programs; and <i>WalkingWorks</i> ® Wellness Program		106-108
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000 (PPO) or \$7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	23-24

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 14. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; \$25 per office visit for primary care physicians and other health care professionals; \$35 per office visit for specialists Non-PPO: You pay all charges	31-32
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: \$150 per day up to \$750 per admission Non-PPO: You pay all charges	69-71
<ul style="list-style-type: none"> Outpatient 	PPO: \$75 per day per facility Non-PPO: You pay all charges	72-75
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	PPO: \$125 copayment for emergency room care; \$50 copayment for urgent care Non-PPO: \$125 copayment for emergency room care Ambulance transport services: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	81-82
<ul style="list-style-type: none"> Medical emergency 	Same as for accidental injury	81, 83-84
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$25 office visit copayment; \$150 per day up to \$750 per inpatient admission Non-PPO: You pay all charges	85-87
Prescription drugs	Retail Pharmacy Program: <ul style="list-style-type: none"> PPO: \$10 generic/\$40 preferred brand-name per prescription/50% coinsurance (\$50 minimum) for non-preferred brand-name drugs/\$50 specialty. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments Non-PPO: You pay all charges Specialty Drug Pharmacy Program: <ul style="list-style-type: none"> \$40 per prescription. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments 	88-99
Dental care	PPO: \$25 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; \$25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	57, 100-101, 105
Special features: Flexible benefits option; Blue Health Connection; Blue Health Assessment; Diabetes Management Incentive Program; MyBlue Customer eService; national provider directory; care management programs; travel benefit/services overseas; Healthy Families Programs; and <i>WalkingWorks</i> ® Wellness Program		106-108
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000 (PPO) per contract per year; some costs do not count toward this protection	23-24

2012 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC), and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN); Postal Career Executive Service (PCES) employees (see RI 70-2EX); and non-career employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Standard Option Self Only	104	\$185.75	\$85.58	\$402.46	\$185.42	\$64.95	\$62.37
Standard Option Self and Family	105	\$414.35	\$198.48	\$897.76	\$430.04	\$152.44	\$146.68
Basic Option Self Only	111	\$168.77	\$56.25	\$365.66	\$121.88	\$37.13	\$34.88
Basic Option Self and Family	112	\$395.21	\$131.73	\$856.28	\$285.42	\$86.95	\$81.68